

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee on Amendments to Constitution and Bylaws

Susan Hubbell, MD, Chair

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2 Your Reference Committee recommends the following consent calendar for acceptance:
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RECOMMENDED FOR ADOPTION

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6 1. Board of Trustees Report 03 - Delegate Apportionment and Pending Members
7 2. Board of Trustees Report 05 - Towards Diversity and Inclusion: A Global Non-
8 discrimination Policy Statement and Benchmark for our AMA
9 3. Board of Trustees Report 12 - Terms and Language in Policies Adopted to Protect
10 Populations from Discrimination and Harassment
11 4. Board of Trustees Report 14 - Specialty Society Representation in the House of
12 Delegates - Five-Year Review
13 5. Council on Constitution and Bylaws Report 1 - Updated Bylaws: Delegate Apportionment
14 and Pending Members
15 6. Council on Ethical and Judicial Affairs Report 1 - Amendment to Opinion 4.2.7,
16 "Abortion"
17 7. Council on Ethical and Judicial Affairs Report 3 - Pandemic Ethics and the Duty of Care
18 8. Resolution 005 - Strengthening Interview Guidelines for American Indian and Alaska
19 Native Medical School, Residency, and Fellowship Applicants
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RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

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23 9. Board of Trustees Report 01 - Opposition to Requirements for Gender-Based Treatment
24 for Athletes
25 10. Board of Trustees Report 04 - Preserving Access to Reproductive Health Services
26 11. Council on Ethical and Judicial Affairs Report 2 - Amendment to Opinion 10.8,
27 "Collaborative Care"
28 12. Resolution 002 - Assessing the Humanitarian Impact of Sanctions
29 13. Resolution 003 – Indigenous Data Sovereignty
30 14. Resolution 008 - Support for Physicians Practicing Evidence-Based Medicine in a
31 Post Dobbs Era
32 15. Resolution 012 – Guidelines on Chaperones for Sensitive Exams
33 16. Resolution 015 - Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
34 17. Resolution 016 - Increasing Female Representation in Oncology Clinical Trials
35 18. Resolution 017 - Supervision of Non-Physician Providers by Physicians
36

1 **RECOMMENDED FOR REFERRAL**

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3 19. Resolution 009 – Medical Decision-Making Autonomy of the Attending Physician

4 20. Resolution 011 - Advocating for the Informed Consent for Access to Transgender
5 Health Care

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7 **Amendments**

8 **If you wish to propose an amendment to an item of business, click here: [Submit New](#)**

9 **[Amendment](#)**

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RECOMMENDED FOR ADOPTION

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- (1) BOARD OF TRUSTEES REPORT 03 – DELEGATE APPORTIONMENT AND PENDING MEMBERS

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RECOMMENDATION:

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Recommendations in Board of Trustees Report 3 be adopted and the remainder of the Report be filed.

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HOD ACTION: Recommendations in Board of Trustees Report 3 referred

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Your Board is cognizant of the fact that some members of the House believe that counting pending members is beneficial to membership and acknowledges the right of the House to determine its makeup. Nevertheless, your Board has concluded that counting pending members for apportionment lacks merit for the reasons outlined above. Also worth noting is that the House will act on Council on Constitution and Bylaws Report 1, which will determine the path taken and may also affect action on this report.

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Your Board of Trustees recommends that Policy G-600.016 be rescinded and the remainder of the report filed.

Testimony for this report was minimal. One delegation expressed concern arguing that counting pending members as members helps them become immediately active and not wait so long to be counted. However, your Reference Committee notes that the Board of Trustees has already considered this argument in its report and recommends that Board of Trustees Report 03 be adopted and the remainder of the report filed.

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- (2) BOARD OF TRUSTEES REPORT 05 - TOWARDS DIVERSITY AND INCLUSION: A GLOBAL NON-DISCRIMINATION POLICY STATEMENT AND BENCHMARK FOR OUR AMA

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RECOMMENDATION:

Recommendations in Board of Trustees Report 5 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 5 adopted and the remainder of the Report filed

Based on a review of internal policies, the Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 602-N-20, and the remainder of this report be filed.

- 1 • That our AMA reaffirm its commitment to complying with all applicable laws, rules or
 2 regulations against discrimination on the basis of protected characteristics, including Title VII of
 3 the Civil Rights Act, The Age Discrimination in Employment Act, and the
 4 Americans with Disabilities Act, among other federal, state and local laws. (New HOD Policy)
 5
 6 • That our AMA reaffirm Policy H-65.965, “Support of Human Rights and Freedom,” as an
 7 overarching non-discrimination policy for the Association. (Reaffirm HOD Policy)
 8
 9 • That our AMA reaffirm Policy H-65.988, “Organizations Which Discriminate,” Policy G-
 10 630.040, “Principles on Corporate Relationships,” and Policy H-65.950, “Terms and Language
 11 in Policies Adopted to Protect Populations from Discrimination and Harassment.” (Reaffirm HOD
 12 Policy)
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 14 • That our AMA provide updates on its comprehensive diversity and inclusion strategy as part of
 15 the annual Board report to the AMA House of Delegates on health equity. (Directive to Take
 16 Action)
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19 Testimony for this report was uniformly and strongly supportive. Testimony noted it is important
 20 that AMA ensure that people are treated with respect and further supported the AMA’s health
 21 equity efforts. Your Reference Committee recommends that the Board of Trustees Report 05
 22 be adopted and the remainder of the report filed.
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 25 (3) BOARD OF TRUSTEES REPORT 12 - TERMS AND
 26 LANGUAGE IN POLICIES ADOPTED TO PROTECT
 27 POPULATIONS FROM DISCRIMINATION AND
 28 HARASSMENT
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30 **RECOMMENDATION:**
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32 **Recommendations in Board of Trustees Report 12 be**
 33 **adopted and the remainder of the Report be filed.**
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35 **HOD ACTION: Recommendations in Board of Trustees Report 12**
 36 **adopted and the remainder of the Report filed**
 37

38 Based on a review of internal policies, the Strategic Plan and Narrative Guide, the Board of
 39 Trustees recommends that the following be adopted, and the remainder of this report be filed:
 40

- 41 1. That our AMA amend Policy H-65.950 by addition and deletion to read as follows:
 42 Our AMA recognizes broad and evolving protected personal characteristics spanning identity,
 43 origin, and status that include those outlined by regulatory authorities overlapping with those
 44 prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine
 45 forward, AMA recommends acknowledges preferred terminology for protected personal
 46 characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed
 47 Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such
 48 as the CDC’s Health Equity Guiding Principles for Inclusive Communication ~~to~~ that may be used
 49 in AMA policies and position statements. (Modify Current HOD Policy)
 50

1 Testimony for this report was unanimously supportive. Testimony concurred with the concept
2 that language and identity often go together, are fluid social constructs that can change over
3 time, and that everyone is entitled to be treated respectfully. Testimony also further noted the
4 report's value in promoting health equity. Your Reference Committee recommends that Board of
5 Trustees Report 12 be adopted and the remainder of the report filed.
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8 (4) BOARD OF TRUSTEES REPORT 14 - SPECIALTY
9 SOCIETY REPRESENTATION IN THE HOUSE OF
10 DELEGATES - FIVE-YEAR REVIEW
11

12 **RECOMMENDATION:**
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14 **Recommendations in Board of Trustees Report 14 be**
15 **adopted and the remainder of the Report be filed.**
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17 **HOD ACTION: Recommendations in Board of Trustees Report 14**
18 **adopted and the remainder of the Report filed**
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21 The Board of Trustees recommends that the following be adopted, and the remainder of this
22 report be filed:
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24 1. The American Association of Neuromuscular and Electrodiagnostic Medicine, American
25 College of Rheumatology, American Society for Dermatologic Surgery Association, American
26 Society for Radiation Oncology, American Society for Surgery of the Hand, American Society of
27 Maxillofacial Surgeons, Association for Clinical Oncology, Radiological Society of North
28 America, Society for Vascular Surgeons, Society of American Gastrointestinal Endoscopic
29 Surgeons, and the Society of Thoracic Surgeons retain representation in the American Medical
30 Association House of Delegates. (Directive to Take Action)
31

32 2. Having failed to meet the requirements for continued representation in the AMA House of
33 Delegates as set forth in AMA Bylaw B-8.5 the Society of Nuclear Medicine and Molecular
34 Imaging be placed on probation and be given one year to work with AMA membership staff to
35 increase their AMA membership. (Directive to Take Action)
36

37 There was brief and minimal testimony in support for the report and your Reference Committee
38 recommends that Board of Trustees Report 14 be adopted and the remainder of the report filed.
39

40 (5) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1
41 - UPDATED BYLAWS: DELEGATE APPORTIONMENT
42 AND PENDING MEMBERS
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44 **RECOMMENDATION:**
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46 **Recommendations in Council on Constitution and**
47 **Bylaws Report 1 be adopted and the remainder of the**
48 **Report be filed.**
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1 **HOD ACTION: Recommendations in Council on Constitution and**
2 **Bylaws Report 1 referred the first stricken sentence of 2.1.1.1 and**
3 **the remainder of the Report adopted and filed**
4

5 The Council on Constitution and Bylaws recommends that the following amendments to the
6 AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the
7 affirmative vote of two-thirds of the members of the House of Delegates present and voting.
8

9 **2.1 Constituent Associations.** Each recognized constituent association granted representation
10 in the House of Delegates is entitled to delegate representation based on the number of seats
11 allocated to it by apportionment, and such additional delegate seats as may be provided under
12 Bylaw 2.1.4.2. Only one constituent association from each U.S. state, commonwealth, territory,
13 or possession shall be granted representation in the House of Delegates.
14

15 **2.1.1 Apportionment.** The apportionment of delegates from each constituent association is one
16 delegate for each 1,000, or fraction thereof, active constituent and active direct members of the
17 AMA within the jurisdiction of each constituent association, as recorded by the AMA as of
18 December 31 of each year.
19

20 ~~2.1.1.1 The December 31 count will include pending members for purposes of apportionment;~~
21 ~~however, pending members shall not be recounted the following year absent membership~~
22 ~~renewal. For 2023 only, the apportionment shall include the greatest of the following numbers:~~
23 ~~the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA~~
24 ~~members consistent with Bylaw 2.1.1; the number of delegates apportioned for 2022 so long as~~
25 ~~that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or~~
26 ~~fraction thereof, AMA members; or for societies that would lose more than 5 delegates from~~
27 ~~their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or~~
28 ~~fraction thereof, AMA members plus 5. Bylaw 2.1.1.1 will sunset as of December 31, 2023 the~~
29 ~~close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it.~~
30

31 **2.1.1.2 Effective Date.** Such apportionment shall take effect on January 1 of the following year
32 and shall remain effective for one year.
33

34 **2.1.1.2.1 Retention of Delegate.** If the membership information as recorded by the AMA as of
35 December 31 warrants a decrease in the number of delegates representing a constituent
36 association, the constituent association shall be permitted to retain the same number of
37 delegates, without decrease, for one additional year, if it promptly files with the AMA a written
38 plan of intensified AMA membership development activities among its members. At the end of
39 the one year grace period, any applicable decrease will be implemented.
40

41 ~~2.1.1.2.1.1 A constituent association that shows a membership loss for 2020 and/or 2021 shall~~
42 ~~be granted an additional one year grace period beyond the one year grace period set forth in~~
43 ~~2.1.1.2.1 without a decrease in the number of delegates. This Bylaw will sunset at the close of~~
44 ~~the 2022 Interim Meeting. A constituent society may not benefit from both this provision and~~
45 ~~2.1.1.1. Bylaw 2.1.1.2.1.1 will sunset as of December 31, 2023.~~
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47 ***

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 2.1.1.4~~2~~.1 using methods specified in AMA policy.

(Modify Bylaws)

Testimony was provided by authors. Your Reference Committee recommends that Council on Constitution and Bylaws Report 01 be adopted and the remainder of the report filed.

- (6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 1 - AMENDMENT TO OPINION 4.2.7,
“ABORTION”

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 1 adopted and the remainder of the Report filed

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)

Testimony was unanimously supportive and noted that the issue of reproductive healthcare is now urgent, and the resolution helps provide appropriate ethics guidance to those who may need it. Testimony further noted that it is physicians who should dictate clinical care and not politicians and that the language helps clarify the current legal situation. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 01 be adopted and the remainder of the report filed.

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2 (7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
3 REPORT 3 - PANDEMIC ETHICS AND THE DUTY OF
4 CARE
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7 **RECOMMENDATION:**

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9 **Recommendations in Council on Ethical and Judicial**
10 **Affairs Report 3 be adopted and the remainder of the**
11 **Report be filed.**
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13 **HOD ACTION: Recommendations in Council on Ethical and**
14 **Judicial Affairs Report 3 adopted and the remainder of the Report**
15 **filed**
16

17 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that
18 Opinion 8.3, "Physician Responsibility in Disaster Response and Preparedness," be amended
19 by addition and deletion as follows and the remainder of this report be filed:
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21 8.3 Physician Responsibility in Disaster Response and Preparedness
22

23 Whether at the national, regional, or local level, responses to disasters require extensive
24 involvement from physicians individually and collectively. Because of their commitment to care
25 for the sick and injured, individual physicians have an obligation to provide urgent medical care
26 during disasters. This obligation holds even in the face of greater than usual risks to physicians'
27 own safety, health, or life.
28

29 ~~However, the physician workforce is not an unlimited resource. Therefore, when providing care~~
30 ~~in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of~~
31 ~~providing care to individual patients versus the need to be available to provide care in the future.~~
32

33 The duty to treat is foundational to the profession of medicine but is not absolute. The health
34 care work force is not an unlimited resource and must be preserved to ensure that care is
35 available in the future. For their part, physicians have a responsibility to protect themselves, as
36 well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So
37 too, health care institutions have responsibilities to support and protect health care
38 professionals and to apportion the risks and benefits of providing care as equitably as possible.
39

40 Many physicians owe competing duties of care as medical professionals 1 and as individual
41 outside their professional roles. In a public health crisis, institutions should provide support to
42 enable physicians to meet compelling personal obligations without undermining the fundamental
43 obligation to patient welfare. In exceptional circumstances, when arrangements to allow the
44 physician to honor both obligations are not feasible, it may be ethically acceptable for a
45 physician to limit participating in care, provided that the institution has made available another
46 mechanism for meeting patients' needs. Institutions should strive to be flexible in supporting
47 physicians in efforts to address such conflicts. The more immediately relevant a physician's
48 clinical expertise is to the urgent needs of the moment and the less that alternative care
49 mechanisms are available, the stronger the professional obligation to provide care despite
50 competing obligations.
51

1 With respect to disaster, whether natural or manmade, individual physicians should:

2
3 (a) Take appropriate advance measures, including acquiring and maintaining appropriate
4 knowledge and skills to ensure they are able to provide medical services when needed.

5
6 Collectively, physicians should:

7
8 (b) Provide medical expertise and work with others to develop public health policies that:

9
10 (i) Are designed to improve the effectiveness and availability of medical services during a
11 disaster

12 (ii) Are based on sound science

13 (iii) Are based on respect for patients

14
15 (c) Advocate for and participate in ethically sound research to inform policy decisions. (Modify
16 HOD/CEJA Policy)

17 Testimony for the report was largely supportive and noted the humanistic aspect of the report.
18 Additional testimony recognized that the report does a good job balancing physicians'
19 responsibilities and patients' needs. Your Reference Committee recommends that Council on
20 Ethical and Judicial Affairs Report 03 be adopted and the remainder of the report be filed.

21
22 (8) RESOLUTION 005 - STRENGTHENING INTERVIEW
23 GUIDELINES FOR AMERICAN INDIAN AND ALASKA
24 NATIVE MEDICAL SCHOOL, RESIDENCY, AND
25 FELLOWSHIP APPLICANTS

26
27 **RECOMMENDATION:**

28
29 **Resolution 005 be adopted.**

30
31 **HOD ACTION: Resolution 005 adopted**

32
33 RESOLVED, That our American Medical Association work with the Accreditation Council for
34 Graduate Medical Education, the National Residency Matching Program, the Association of
35 American Medical Colleges, and other interested parties to eliminate questioning about or
36 discrimination based on American Indian and Alaska Native blood quantum during the medical
37 school, residency, and fellowship application process. (Directive to Take Action)

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39 Testimony was unanimously supportive of the report as written. Your Reference Committee
40 recommends Resolution 005 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

(9) BOARD OF TRUSTEES REPORT 1 – OPPOSITION TO REQUIREMENTS FOR GENDER-BASED TREATMENTS FOR ATHLETES

RECOMMENDATION A

Recommendation 3 in Board of Trustees Report 1 be amended by addition and deletion to read as follows:

That our AMA oppose satisfying third-party requirements physician participation in any practices intended to officially certify or confirm an athlete’s gender through physician participation. for the purposes of satisfying third party requirements. (New HOD Policy)

RECOMMENDATION B

Board of Trustees Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 1 adopted as amended and the remainder of the Report filed

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

- 1. That our American Medical Association (AMA) oppose mandatory 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)

Testimony for this report was mixed. Multiple delegations expressed strong support, noting that transgender individuals and individuals with DSD have been discriminated against on numerous fronts and that physicians should not be hesitant to support gender equity. Testimony further notes that no two individuals are the same, and there is a wide variance among individuals, and

1 that treatment should not be standardized. The majority of opposing testimony noted that the
2 report does not consider the impact on cisgender individuals. Your Reference Committee notes
3 that the balance of testimony was in support of the report. Your Reference Committee offers a
4 clarifying amendment responding to concerns of physicians participating as team physicians,
5 and recommends that the report be adopted as amended and that the rest of the report be filed.
6

7 (10) BOARD OF TRUSTEES REPORT 04 - PRESERVING
8 ACCESS TO REPRODUCTIVE HEALTH SERVICES
9

10 **RECOMMENDATION A**

11 **Recommendation 4 in Board of Trustees Report be**
12 **amended by addition and deletion to read as follows:**
13

14
15 That Policy H-5.993, “Right to Privacy in Termination
16 of Pregnancy” be amended by addition and deletion as
17 follows:
18

19 The AMA reaffirms existing policy that (1) abortion is a
20 human right and the practice of medicine and requires
21 the personal performance or supervision by an
22 appropriately licensed physician a medical procedure
23 and ~~that~~ should be performed ~~only by a duly licensed~~
24 physician in conformance with standards of good
25 medical practice and the laws of the state; and (2) no
26 physician or other professional personnel shall be
27 required to perform an act violative of good medical
28 judgment or personally held moral principles. In these
29 circumstances, ~~good medical practice requires only~~
30 that the a physician or other professional may
31 withdraw from the case so long as the withdrawal is
32 consistent with good medical practice and ethical
33 guidance on the exercise of conscience; (3) The AMA
34 further supports the position that ~~the early~~ termination
35 of pregnancy is a medical matter between the patient
36 and the physician, subject to the physician's clinical
37 judgment, the patient's informed consent, and the
38 ability to perform the procedure safely availability of
39 appropriate facilities. (Modify Current HOD Policy)
40

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42 **RECOMMENDATION B**

43
44 That Policy H-5.982, “Late-Term Pregnancy
45 Termination Techniques” be rescinded in lieu of
46 recommendation 4 of the Board of Trustees Report 04
47 (Rescind HOD Policy)
48

49 **RECOMMENDATION C**
50

1 **Recommendation 5, subsection (3), of the Board of**
 2 **Trustees Report 04 be amended by addition to read as**
 3 **follows:**

4
 5 **(3) will work with interested state medical societies**
 6 **and medical specialty societies to vigorously advocate**
 7 **for broad, equitable access to reproductive health**
 8 **services, including fertility treatments, fertility**
 9 **preservation, contraception, and abortion;**

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 11
 12 **RECOMMENDATION D**

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 14 **Recommendations in Board of Trustees Report 4 be**
 15 **adopted as amended and the remainder of the Report**
 16 **be filed.**

17
 18 **HOD ACTION: Recommendations in Board of Trustees Report 4**
 19 **adopted as amended and the remainder of the Report filed**

20
 21 The Board recommends that the following recommendations be adopted and that the remainder
 22 of the report be filed.

23
 24 1. That Policy H-5.993, "Right to Privacy in Termination of Pregnancy" be amended by addition
 25 and deletion as follows:

26
 27 The AMA reaffirms existing policy that (1) abortion is the practice of medicine and requires the
 28 personal performance or supervision by an appropriately licensed physician a medical
 29 procedure and should be performed only by a duly licensed physician in conformance with
 30 standards of good medical practice and the laws of the state; ~~and~~ (2) no physician or other
 31 professional personnel shall be required to perform an act violative of good medical judgment or
 32 personally held moral principles. In these circumstances ~~good medical practice requires only~~
 33 ~~that the a~~ physician or other professional may withdraw from the case so long as the withdrawal
 34 is consistent with good medical practice and ethical guidance on the exercise of conscience; (3)
 35 The AMA further supports the position that the early termination of pregnancy is a medical
 36 matter between the patient and the physician, subject to the physician's clinical judgment, the
 37 patient's informed consent, and the ability to perform the procedure safely availability of
 38 appropriate facilities. (Modify Current HOD Policy)

39
 40 2. That Policies H-5.995, "Abortion," and Policy H-5.983, "Pregnancy Termination," be
 41 rescinded. (Rescind HOD Policy)

42
 43 3. That Policy H-5.990, "Policy on Abortion," be amended by addition as follows:

44
 45 The issue of personal support of or opposition to abortion is a matter for members of the AMA to
 46 decide individually, based on personal values or beliefs. The AMA will take no action which may
 47 be construed as an attempt to alter or influence the personal views of individual physicians
 48 regarding abortion procedures. (Modify HOD Policy)

49
 50 4. That Policy H-5.982, "Late-Term Pregnancy Termination Techniques," be amended by
 51 addition and deletion as follows:

1
2 (1) The term “partial birth abortion” is not a medical term. The AMA will use the term “intact
3 dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the
4 following elements: deliberate dilatation of the cervix, usually over a sequence of days;
5 instrumental or manual conversion of the fetus to a footling breech; breech extraction of the
6 body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect
7 vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation
8 and evacuation (D&E) procedures more commonly used to induce abortion after the first
9 trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA. (2)
10 According to the scientific literature, there does not appear to be any identified situation in which
11 intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been
12 raised about intact D&X. The AMA recommends that the procedure not be used unless
13 alternative procedures pose materially greater risk to the woman. The physician must, however,
14 retain the discretion to make that judgment, acting within standards of good medical practice
15 and in the best interest of the patient. (3) The viability of the fetus and the time when viability is
16 achieved may vary with each pregnancy. ~~In the second trimester w~~When viability may be in
17 question, it is the physician who should determine the viability of a specific fetus, using the latest
18 available diagnostic technology. (4) ~~In recognition of the constitutional principles regarding the~~
19 ~~right to an abortion articulated by the Supreme Court in Roe v. Wade, and~~ In keeping with the
20 science and values of medicine, the AMA recommends that abortions not be performed in the
21 third trimester except in cases of serious fetal anomalies incompatible with life. Although third-
22 trimester abortions can be performed to preserve the life or health of the mother, they are, in
23 fact, generally not necessary for those purposes. Except in extraordinary circumstances,
24 maternal health factors which demand termination of the pregnancy can be accommodated
25 without sacrifice of the fetus, and the near certainty of the independent viability of the fetus
26 argues for ending the pregnancy by appropriate delivery. (Modify Current HOD Policy)

27
28 5. Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended by
29 deletion as follows:

30
31 Our AMA: (1) recognizes that healthcare, including reproductive health services like
32 contraception and abortion, is a human right; (2) opposes limitations on access to evidence-
33 based reproductive health services, including fertility treatments, contraception, and abortion;
34 (3) will work with interested state medical societies and medical specialty societies to vigorously
35 advocate for broad, equitable access to reproductive health services, including fertility
36 treatments, contraception, and abortion; (4) supports shared decision-making between patients
37 and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the
38 basic medical principle that clinical assessments, such as viability of the pregnancy and safety
39 of the pregnant person, are determinations to be made only by healthcare professionals with
40 their patients; (6) opposes the imposition of criminal and civil penalties or 1 other retaliatory
41 efforts against patients, patient advocates, physicians, other healthcare workers, and health
42 systems for receiving, assisting in, referring patients to, or providing reproductive health
43 services; (7) will advocate for legal protections for patients who cross state lines to receive
44 reproductive health services, including contraception and abortion, or who receive medications
45 for contraception and abortion from across state lines, and legal protections for those that
46 provide, support, or refer patients to these services; and ~~(8) will review the AMA policy~~
47 ~~compendium and recommend policies which should be amended or rescinded to reflect these~~
48 ~~core values, with report back at the 2022 Interim Meeting.~~ (Modify Current HOD Policy)

49
50

1 Testimony was strongly supportive of this report. An amendment was proffered that addressed
2 various concerns and received wide support. The amendment addressed the problem referring
3 to “late-term pregnancy”, noting that the term is not scientifically accurate and is misleading to
4 the public. Another amendment removed language referring to adherence to “laws of the state”
5 in light of the Dobbs ruling. Proffered amendment also provides language that “abortion is a
6 human right”. Some opposing testimony noted that this language may be inflammatory, but the
7 balance of testimony was supportive. Another amendment suggested the addition of “fertility
8 preservation” in the listing of types of reproductive health services. In consideration of broad
9 support of the report and proffered amendments, your Reference Committee recommends that
10 Board of Trustees Report 04 be amended and that the rest of the report be filed
11
12

13 (11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
14 REPORT 2 - AMENDMENT TO OPINION 10.8,
15 “COLLABORATIVE CARE”
16

17 **RECOMMENDATION A:**
18

19 **The recommendation in the Council on Ethical and**
20 **Judicial Affairs Report 2 be amended by addition with**
21 **concurrence of the Council on Ethical and Judicial**
22 **Affairs, to read as follows:**
23

24 **In health care, teams that collaborate effectively can**
25 **enhance the quality of care for individual patients. By**
26 **being prudent stewards and delivering care efficiently,**
27 **teams also have the potential to expand access to care**
28 **for populations of patients. Such teams are defined by**
29 **their dedication to providing patient-centered care,**
30 **protecting the integrity of the patient-physician**
31 **relationship, sharing mutual respect and trust,**
32 **communicating effectively, sharing accountability and**
33 **responsibility, and upholding common ethical values**
34 **as team members.**
35

36 **RECOMMENDATION B:**
37

38 **That the Council on Ethical and Judicial Affairs Report**
39 **2 be adopted as amended, and the remainder of this**
40 **report filed.**
41

42 **HOD ACTION: That the Council on Ethical and Judicial Affairs**
43 **Report 2 adopted as amended, and the remainder of this report**
44 **filed**
45

46 In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion
47 10.8, “Collaborative Care,” be amended as follows and the remainder of this report be filed:
48

49 In health care, teams that collaborate effectively can enhance the quality of care for individual
50 patients. By being prudent stewards and delivering care efficiently, teams also have the
51 potential to expand access to care for populations of patients. Such teams are defined by their

1 dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician~~
2 ~~relationship~~, sharing mutual respect and trust, communicating effectively, sharing accountability
3 and responsibility, and upholding common ethical values as team members.
4

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

10
11 An effective team requires the vision and direction of an effective 1 leader. In medicine, this
12 means having a clinical leader who will ensure that the team as a whole functions effectively
13 and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By
14 virtue of their thorough and diverse training, experience, and knowledge, physicians have a
15 distinctive appreciation of the breadth of health issues and treatments that enables them to
16 synthesize the diverse professional perspectives and recommendations of the team into an
17 appropriate, coherent plan of care for the patient.
18

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

20
21 (a) Model ethical leadership by:

22
23 (i) Understanding the range of their own and other team members' skills and expertise and roles
24 in the patient's care

25 (ii) Clearly articulating individual responsibilities and accountability

26 (iii) Encouraging insights from other members and being open to adopting them and

27 (iv) Mastering broad teamwork skills
28

29 (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and
30 commitment to continuous improvement.
31

32 (c) Help clarify expectations to support systematic, transparent decision making.
33

34 (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in
35 which each member's opinion is heard and considered and team members share accountability
36 for decisions and outcomes.
37

38 (e) Communicate appropriately with the patient and family, ~~and respecting their~~ unique
39 relationship of patient and family as members of the team.
40

41 (f) Assure that all team members are describing their profession and role.
42

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

44
45 (fg) Advocate for the resources and support health care teams need to collaborate effectively in
46 providing high-quality care for the patients they serve, including education about the principles
47 of effective teamwork and training to build teamwork skills.
48

49 (gh) Encourage their institutions to identify and constructively address barriers to effective
50 collaboration.
51

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

4
5 (j) Promote a culture of respect, collegiality and transparency among all health care personnel.

6
7 (Modify HOD/CEJA Policy)
8
9

10
11 The Council on Ethical and Judicial Affairs testified that the strikethrough of the language:
12 “protecting the integrity of the patient-physician relationship” was an error and they accept this
13 language as part of the report. Your Reference Committee recommends that Council on Ethical
14 and Judicial Affairs report 02 be adopted as amended and the rest of the report be filed.
15

16
17 **(12) RESOLUTION 002 - ASSESSING THE HUMANITARIAN**
18 **IMPACT OF SANCTIONS**

19
20 **Alternate Resolution 002 be adopted in lieu of**
21 **Resolution 002 and Resolution 006.**

22
23 **ASSESSING THE HUMANITARIAN IMPACT OF**
24 **SANCTIONS**

25
26 **RESOLVED, That our American Medical Association**
27 **recognize that economic sanctions can negatively**
28 **impact health and exacerbate humanitarian crises**
29 **(New HOD Policy); and be it further**
30

31
32 **RESOLVED, that policy H-65.993 by amended by**
33 **addition as follows:**
34

35 **Our American Medical Association will (1) implore all**
36 **parties at all times to understand and minimize the**
37 **health costs of war on civilian populations generally**
38 **and the adverse effects of physician persecution in**
39 **particular, (2) support the efforts of physicians around**
40 **the world to practice medicine ethically in any and all**
41 **circumstances, including during wartime, or episodes**
42 **of civil strife, or sanctions and condemn the military**
43 **targeting of health care facilities and personnel and**
44 **using denial of medical services as a weapon of war,**
45 **by any party, wherever and whenever it occurs, and (3)**
46 **advocate for the protection of physicians’ rights to**
47 **provide ethical care without fear of persecution; and**
48 **be it further**
49
50

1 **RESOLVED, that policy H-65.994 be amended by**
 2 **addition and deletion as follows:**

3
 4
 5 **The AMA (1) supports the provision of food, medicine**
 6 **and medical equipment to noncombatants threatened**
 7 **by natural disaster, ~~or~~ military conflict or sanctions**
 8 **within their country through appropriate relief**
 9 **organizations; (2) expresses its concern about the**
 10 **disappearance of physicians, medical students and**
 11 **other health care professionals, with resulting**
 12 **inadequate care to the sick and injured of countries in**
 13 **turmoil; (3) urges appropriate organizations to**
 14 **transmit these concerns to the affected country's**
 15 **government; and (4) asks appropriate international**
 16 **health organizations to monitor the status of medical**
 17 **care, medical education and treatment of medical**
 18 **personnel in these countries, to inform the world**
 19 **health community of their findings, and to encourage**
 20 **efforts to ameliorate these problems.**

21
 22 **HOD ACTION: Alternate Resolution 002 adopted in lieu of**
 23 **Resolutions 002 and 006.**

24
 25 RESOLVED, That our American Medical Association recognize that economic sanctions can
 26 negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it
 27 further

28
 29 RESOLVED, That our AMA support efforts to study the humanitarian impact of economic
 30 sanctions imposed by the United States. (New HOD Policy)

31
 32
 33 Testimony was mixed for this resolution. Opposing testimony noted that the resolution relates
 34 to foreign policy and may be outside the purview of the AMA. Concerns were also raised that
 35 the second resolve is asking our AMA to “support efforts to study” the impact of sanctions. The
 36 substituted Resolution 002 addressed this concern. Your Reference Committee notes that the
 37 whereas clauses in the report address policies H-65.993 and H-65.994, which broadly address
 38 issues of medical access to countries in turmoil and health costs of war on civilian populations,
 39 while not addressing the harmful effects of sanctions. Your Reference Committee recommends
 40 amending both these existing policies to incorporate references to sanctions in lieu of the
 41 second resolve of Resolution 002, while also adopting the first resolve clause of Resolution 002
 42 and 006.

43
 44
 45 (13) **RESOLUTION 003 – INDIGENOUS DATA SOVEREIGNTY**

46 **RECOMMENDATION A:**
 47
 48
 49

1 **The second resolve of Resolution 003 be amended by**
2 **addition and deletion to read as follows:**

3
4 **RESOLVED, That our AMA support that AI/AN Tribes**
5 **and Villages' Institutional Review Boards (IRBs) and**
6 **research departments retain the right to oversee and**
7 **regulate the collection, ownership, and management of**
8 **research data ~~generated by~~ with the consent of their**
9 **members, and that individual members of AI/AN Tribes**
10 **and Villages retain their autonomy and privacy**
11 **regarding research data shared with researchers,**
12 **AI/AN Tribes and Villages, and governments,**
13 **consistent with existing protections under 45 CFR 46**
14 **(New HOD Policy)**

15
16 **RECOMMENDATION B:**

17
18
19 **The third resolve of Resolution 003 be amended by**
20 **addition:**

21
22 **“RESOLVED, that our AMA encourage the use and**
23 **regular review of data-sharing agreements for all**
24 **studies between academic medical centers and AI/AN**
25 **Tribes and Villages be mutually agreed upon and**
26 **aligned with AI/AN Tribes' and Villages' preferences.”**

27
28
29 **RECOMMENDATION C:**

30
31 **Resolution 003 be adopted as amended.**

32
33 **HOD ACTION: Resolution 003 adopted as amended**

34
35 RESOLVED, That our American Medical Association recognize that American Indian and
36 Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted
37 before the conduct of research specific to their members, lands, and properties (New HOD
38 Policy); and be it further

39
40 RESOLVED, That our AMA support that AI/AN Tribes and Villages' Institutional Review Boards
41 (IRBs) and research departments retain the right to oversee and regulate the collection,
42 ownership, and management of research data generated by their members, and that individual
43 members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research
44 data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with
45 existing protections under 45 CFR 46 (New HOD Policy); and it be further

46
47 RESOLVED, That our AMA encourage the use and regular review of data-sharing agreements
48 for all studies between academic medical centers and AI/AN Tribes and Villages (New HOD
49 Policy); and be it further

50

1 RESOLVED, That our AMA encourage the National Institutes of Health and other stakeholders
2 to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the
3 creation and maintenance of IRBs. (New HOD Policy)
4

5
6 Testimony was heard in support of Resolution 003, with proffered amendments. It was
7 generally agreed that given past injustices, tribes should have the power to regulate their own
8 affairs by means of tribal IRBs. Some testimony suggested that the call for funding of tribal IRBs
9 in resolve 4 could create a conflict of interest, but other testimony clarified standard IRB
10 practice. Your Reference Committee recommends that Resolution 003 be adopted as amended.
11

12 (14) RESOLUTION 008 - SUPPORT FOR PHYSICIANS
13 PRACTICING EVIDENCE-BASED MEDICINE IN A POST
14 DOBBS ERA
15

16 **RECOMMENDATION A:**
17

18 **The first resolve of Resolution 008 be amended by**
19 **addition and deletion to read as follows:**
20

21 **RESOLVED, That our American Medical Association**
22 **Task Force developed under HOD Policy G-605.009,**
23 **“Establishing A Task Force to Preserve the Patient-**
24 **Physician Relationship When Evidence-Based,**
25 **Appropriate Care Is Banned or Restricted,” publish a**
26 **report with annual updates with recommendations**
27 **provide policy and strategies including policies,**
28 **strategies, and resources for physicians who are**
29 **required by medical judgment and ethical standards of**
30 **care to act against state and federal laws (Directive to**
31 **Take Action)**
32

33 **RECOMMENDATION B:**
34

35 **The second resolve of Resolution 008 be amended by**
36 **addition and deletion to read as follows:**
37

38 **RESOLVED, That our AMA work to provide facilitate**
39 **support, including legal support through the AMA**
40 **Litigation Center, as may be appropriate, to physicians**
41 **that are targeted for practicing in accordance with**
42 **accepted standards of medical care and medical ethics**
43 **in the face of legal constraint or any other disciplinary**
44 **action (Directive to Take Action)**
45

46 **RECOMMENDATION C:**

47 **Resolution 008 be adopted as amended.**
48

49 **HOD ACTION: Resolution 008 adopted as amended**
50

1 RESOLVED, That our American Medical Association Task Force developed under HOD Policy
2 G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When
3 Evidence-Based, Appropriate Care Is Banned or Restricted," provide policy and strategies to
4 support physicians individually and through their medical organizations when they are required
5 by medical and ethical standards of care to act against state and federal laws (Directive to Take
6 Action); and be it further
7

8 RESOLVED, That our AMA work to provide support, including legal support through the AMA
9 Litigation Center, as may be appropriate, to physicians that are targeted for practicing in
10 accordance with accepted standards of medical care and medical ethics in the face of legal
11 constraint or any other disciplinary action (Directive to Take Action); and be it further
12

13 RESOLVED, That our AMA advocate for affirmative protections for "conscientious provision" of
14 care in accordance with accepted standards of medical care and medical ethics in hostile
15 environments on par with protection of "conscientious objection." (Directive to Take Action)
16

17 Testimony was heard in support of Resolution 008 and the proffered amendments. An
18 amendment asked for our AMA to advocate for expanded liability insurance coverage for
19 physicians who are subject to civil or criminal prosecution for practicing evidence-based
20 medicine. Your Reference Committee acknowledges an unintended consequence of significant
21 insurance rate increases. Your Reference Committee notes the AMA Litigation Center is an
22 appropriate source of support for members in these situations, and they encourage members to
23 use this resource and Your Reference Committee recommends that Resolution 008 be adopted
24 as amended.
25

26
27 (15) RESOLUTION 012 - GUIDELINES ON CHAPERONES
28 FOR SENSITIVE EXAMS
29
30

31 **RECOMMENDATION A:**
32

33 **Resolution 012 be amended by addition to read as**
34 **follows**
35

36 **RESOLVED, That our American Medical Association**
37 **ask the Council on Ethical and Judicial Affairs to**
38 **consider amending E-1.2.4, "Use of Chaperones in**
39 **Code of Medical Ethics," to ensure that it is most in**
40 **line with the current best practices for adult and**
41 **pediatric populations and potentially considers the**
42 **following topics: a) opt-out chaperones for breast,**
43 **genital, and rectal exams; b) documentation**
44 **surrounding the use or not-use of chaperones; c) use**
45 **of chaperones for patients without capacity; d) asking**
46 **patients' consent regarding the gender of the**
47 **chaperones and attempting to accommodate that**
48 **preference as able; and (e) Use of chaperone at**
49 **physician request when physician deems necessary.**
50 **(Directive to Take Action)**
51

RECOMMENDATION B:**Resolution 012 be adopted as amended.****HOD ACTION: Resolution 012 adopted as amended**

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)

Testimony was generally in support of this resolution. Further testimony notes that there are "nuances to chaperone use in pediatric practice." An additional resolve was proffered that asks our "AMA advocate for State and federal legislative and regulatory changes to facilitate reimbursement for chaperone services". There was support for the amendment, however your Reference Committee notes that the nature of the amendment is outside the scope of the current resolution, which is focused on exam guidelines. Such an amendment would be more appropriate as its own future resolution. Hence, your Reference Committee recommend that Resolution 12 be adopted as amended.

(16) RESOLUTION 015 - RESTRICTING DEROGATORY AND STIGMATIZING LANGUAGE OF ICD-10 CODES

RECOMMENDATION A:**That the resolve for Resolution 015 be amended by addition and deletion to read as follows:**

RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention and the National Center for Health Statistics ICD-10 Coordination and Maintenance Committee to advocate for the World Health Organization to implement adopt destigmatizing terminology in ICD-10 and future ICD codes. ~~that will cover utilize gender-affirming health care services as well as human immunodeficiency virus pre-exposure prophylaxis services and medications.~~

RECOMMENDATON B:**Resolution 015 be adopted as amended.****HOD ACTION: Resolution 015 adopted as amended with addition and deletion as follows:**

1 **RESOLVED, That our American Medical Association collaborate**
 2 **with the Centers for Disease Control and Prevention and the**
 3 **National Center for Health Statistics ICD-10 Coordination and**
 4 **Maintenance Committee to advocate for the World Health**
 5 **Organization to ~~implement~~ adopt destigmatizing terminology in**
 6 **ICD-10 and future ICD codes and to eliminate existing**
 7 **stigmatizing diagnostic synonyms. ~~that will cover utilize gender-~~**
 8 **~~affirming health care services as well as human~~**
 9 **~~immunodeficiency virus pre-exposure prophylaxis services and~~**
 10 **~~medications~~**

12 RESOLVED, That our American Medical Association collaborate with the World Health
 13 Organization to implement destigmatizing terminology in ICD-10 that will cover gender-affirming
 14 health care services as well as human immunodeficiency virus pre-exposure prophylaxis
 15 services and medications. (Directive to Take Action)

18 Testimony was heard in support of Resolution 15, together with amendments. It was also
 19 mentioned that the language of the codes needs to be fully overhauled in order to be genuinely
 20 inclusive, and that changing a few distinct codes will not accomplish this. Additional testimony
 21 questioned the value of revising ICD-10 codes when ICD-11 has already been developed by
 22 World Health Organization. Since the timeline for implementing ICD-11 in the U.S. is unknown
 23 your Reference Committee recommends amendments that allow the resolution to address
 24 current difficulties with ICD-10 as well as to support destigmatizing language in future ICD
 25 codes. Your Reference Committee recommends Resolution 015 be adopted as amended.

28 (17) **RESOLUTION 016 – INCREASING FEMALE**
 29 **REPRESENTATION IN ONCOLOGY CLINICAL TRIALS**

32 **Recommendation: That Resolution 016 be amended**
 33 **by addition and deletion:**

36 **Increasing Minority, and Female, and other**
 37 **Underrepresented Group Participation in Clinical**
 38 **Research H460.911**

- 41 **1. Our AMA advocates that:**
 42 **a. The Food and Drug Administration (FDA) and**
 43 **National Institutes of Health (NIH) conduct annual**
 44 **surveillance of clinical trials by gender, race, and**
 45 **ethnicity, including consideration of pediatric and**
 46 **elderly populations, to determine if proportionate**
 47 **representation of women and minorities is maintained**
 48 **in terms of enrollment and retention. This surveillance**
 49 **effort should be modeled after National Institute of**
 50 **Health guidelines on the inclusion of women and**
 51 **minority populations. b. The FDA have a page on its**

1 web site that details the prevalence of minorities and
2 women in its clinical trials and its efforts to increase
3 their enrollment and participation in this research; and
4 c. Resources be provided to community level agencies
5 that work with those minorities, and females, and other
6 underrepresented groups who are not proportionately
7 represented in clinical trials to address issues of lack
8 of access, distrust, and lack of patient awareness of
9 the benefits of trials in their health care. These
10 minorities include Black Individuals/African
11 Americans, Hispanics, Asians/Pacific Islanders/Native
12 Hawaiians, and Native Americans.

13
14
15 2. Our AMA recommends the following activities to the
16 FDA in order to ensure proportionate representation of
17 minorities, and females, and other underrepresented
18 groups in clinical trials: a. Increased fiscal support for
19 community outreach programs; e.g., culturally relevant
20 community education, community leaders' support,
21 and listening to community's needs; b. Increased
22 outreach to female all physicians to encourage
23 recruitment of ~~minority and female~~ patients from
24 underrepresented groups in clinical trials; c.
25 Continued ~~minority physician education for all~~
26 physicians and physicians-in-training on clinical trials,
27 subject recruitment, subject safety, and possible
28 expense reimbursements, and that this education
29 encompass discussion of barriers that currently
30 constrain appropriate recruitment of underrepresented
31 groups and methods for increasing trial accessibility
32 for patients female and minority subject recruitment
33 and methods for increasing trial accessibility for
34 patients such as community partnerships, optimized
35 patient centered locations for accessing trials, and the
36 ready availability of transportation to and from trial
37 locations and child care services;

38
39 d. Support for the involvement of minority physicians
40 in the development of partnerships between minority
41 communities and research institutions; and e. Fiscal
42 support for minority, and female, and other
43 underrepresented groups recruitment efforts and
44 increasing trial accessibility ~~through optimized~~
45 patient centered locations for accessing trials, the
46 ready availability of transportation to and from trial
47 locations, child care services, and transportation, child
48 care, reimbursements, and location.

49
50 3. Our AMA advocates that specific results of
51 outcomes in all clinical trials, both pre- and post-FDA

1 approval, are to be determined for all subgroups of
2 gender, race and ethnicity, including consideration of
3 pediatric and elderly populations; and that these
4 results are included in publication and/or freely
5 distributed, whether or not subgroup differences exist.
6

7 **HOD ACTION: Resolution 016 amended by addition and deletion**
8

9
10 RESOLVED, That our AMA amend H-460.911, Increasing Minority Participation in Clinical
11 Research, by addition as follows:
12

13 **Increasing Minority and Female Participation in Clinical Research H-460.911**
14

15 1. Our AMA advocates that:

16 a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct
17 annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of
18 pediatric and elderly populations, to determine if proportionate representation of women and
19 minorities is maintained in terms of enrollment and retention. This surveillance effort should be
20 modeled after National Institute of Health guidelines on the inclusion of women and minority
21 populations.

22 b. The FDA have a page on its web site that details the prevalence of minorities and women in
23 its clinical trials and its efforts to increase their enrollment and participation in this research; and
24 c. Resources be provided to community level agencies that work with those minorities and
25 females who are not proportionately represented in clinical trials to address issues of lack of
26 access, distrust, and lack of patient awareness of the benefits of trials in their health care.
27 These minorities include Blacks/African Americans, Hispanics, Asians/Pacific Islanders/Native
28 Hawaiians, and Native Americans.
29

30 2. Our AMA recommends the following activities to the FDA in order to ensure proportionate
31 representation of minorities and females in clinical trials:

32 a. Increased fiscal support for community outreach programs; e.g., culturally relevant
33 community education, community leaders' support, and listening to community's needs;
34 b. Increased outreach to ~~female~~ all physicians to encourage recruitment of minority and female
35 patients in clinical trials;
36 c. Continued ~~minority physician~~ physician education for all physicians and physicians-in-training on clinical
37 trials, subject recruitment, subject safety, and possible expense reimbursements, and that this
38 education encompass discussion of barriers that currently constrain appropriate female and
39 minority subject recruitment and methods for increasing trial accessibility for patients such as
40 community partnerships, optimized patient-centered locations for accessing trials, and the ready
41 availability of transportation to and from trial locations and child care services;
42 d. Support for the involvement of minority physicians in the development of partnerships
43 between minority communities and research institutions; and
44 e. Fiscal support for minority and female recruitment efforts and increasing trial accessibility
45 through optimized patient-centered locations for accessing trials, the ready availability of
46 transportation to and from trial locations, child care services, and ~~transportation, child care,~~
47 reimbursements, and ~~location.~~
48

49 3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-
50 FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including

1 consideration of pediatric and elderly populations; and that these results are included in
2 publication and/or freely distributed, whether or not subgroup differences exist.

3
4 Testimony was heard in strong support of Resolution 016, provided that proffered amendments
5 were incorporated into the final version. Testimony reflected concern that the language of the
6 resolution should specifically include pregnant people and members of underrepresented
7 groups in addition to female study participants. Testimony generally supported the claim that
8 research has not enrolled women in proportion to their disease burden, and that all physicians
9 should be educated about strategies for equitable study enrollment. In Resolve 2e it is noted
10 that certain specific strategies for reducing barriers should be fiscally supported, and testimony
11 was heard that support for telemedicine should be included. However, your Reference
12 Committee concluded that general language about fiscal support was more appropriate than a
13 determinate list of strategies. Your Reference Committee recommends that Resolution 16 be
14 adopted as amended.

15
16 (18) RESOLUTION 017 - SUPERVISION OF NON-PHYSICIAN
17 PROVIDERS BY PHYSICIANS

18
19
20 **RECOMMENDATION A:**

21
22 **First resolve of Resolution 017 be amended by**
23 **addition and deletion:**

24
25 **RESOLVED, That our American Medical Association advocate to relevant entities**
26 **~~with a goal to ensure physicians on staff receive written notification when their~~**
27 **~~license is being used to document “supervision” of non-physician practitioners;~~**
28 **~~Physician supervision should be explicitly defined and mutually agreed upon~~**
29 **(Directive to Take Action); and be it further**

30
31 **RECOMMENDATION B:**

32
33 **Amended by addition of a new resolve for Resolution**
34 **017:**

35
36 **RESOLVED, That our AMA advocate that physician**
37 **supervision should be explicitly defined and mutually**
38 **agreed upon (Directive to Take Action); and be it**
39 **further**

40
41 **RECOMMENDATION C:**

42 **The third resolve of Resolution 017 be amended by deletion:**

43
44 **RESOLVED, That our AMA advocate that organizations, institutions, and medical**
45 **staffs that have physicians who participate in supervisory duties for non-**
46 **physician practitioners have processes and procedures in place that have been**
47 **developed with appropriate clinical physician input. ~~These should be adequate to~~**
48 **~~assure patient safety and appropriate clinical care and are fully disclosed to~~**
49 **physicians (Directive to Take Action); and be it further**
50

1 **RECOMMENDATION D:**

2
3 **The fourth resolve of Resolution 017 be amended by addition and deletion:**

4
5 **RESOLVED, That our AMA advocate that physicians be able to report professional**
6 **concerns about care provided by the non-physician practitioners to the**
7 **appropriate leadership with protections against retaliation ~~so as not to be~~**
8 **~~retaliated against by the physician's employer in any way~~ (Directive to Take**
9 **Action).**

10
11 **RECOMMENDATION E:**

12
13 **Resolution 017 be adopted as amended.**

14
15 **RECOMMENDATION F:**

16
17 **The title of Resolution 017 be changed to read as follows:**

18
19 **SUPERVISION OF NON-PHYSICIAN PRACTITIONERS BY PHYSICIANS**

20
21
22 **HOD ACTION: Resolution 017 adopted as amended with change**
23 **in title to read as follows:**

24
25 **SUPERVISION OF NON-PHYSICIAN PRACTITIONERS BY**
26 **PHYSICIANS**

27
28 RESOLVED, That our American Medical Association advocate to relevant entities with a goal to
29 ensure physicians on staff receive written notification when their license is being used to
30 document "supervision" of non-physician practitioners. Physician supervision should be explicitly
31 defined and mutually agreed upon (Directive to Take Action); and be it further

32
33 RESOLVED, That our AMA advocate for advanced notice and disclosure to the physician
34 before they are hired or as soon as practicably known by provider organizations and institutions
35 that anticipate physician supervision of non-physician practitioners as a condition for physician
36 employment (Directive to Take Action); and be it further

37
38 RESOLVED, That our AMA advocate that organizations, institutions, and medical staffs that
39 have physicians who participate in supervisory duties for non-physician practitioners have
40 processes and procedures in place that have been developed with appropriate clinical physician
41 input. These should be adequate to assure patient safety and appropriate clinical care and are
42 fully disclosed to physicians (Directive to Take Action); and be it further

43
44 RESOLVED, That our AMA advocate that physicians be able to report professional concerns
45 about care provided by the non-physician practitioners to the appropriate leadership with
46 protections so as not to be retaliated against by the physician's employer in any way (Directive
47 to Take Action).

48
49 Significant supportive testimony was heard for Resolution 017. A request was made for
50 language to be simplified. Your Reference Committee has made changes accordingly and
51 recommends Resolution 017 be adopted as amended.

RECOMMENDED FOR REFERRAL

1
2
3
4 (19) RESOLUTION 009 – MEDICAL DECISION-MAKING
5 AUTONOMY OF THE ATTENDING PHYSICIAN
6

7 **RECOMMENDATION:**
8

9 **Resolution 009 be referred with report back in I-23.**

10 **HOD ACTION: Resolution 009 referred with report back in I-23**
11
12

13 RESOLVED, That our American Medical Association advocate that no matter what may change
14 in regard to a physician's employment or job status, that there is a sacred relationship between
15 an attending physician and his/her patient that leads the patient's attending physician to hold the
16 ultimate authority in the medical decision-making that affects that patient (Directive to Take
17 Action); and be it further
18

19 RESOLVED, That our AMA advocate strongly that if there is a unique circumstance that puts
20 the attending physician's care into question by a hospital administrator of any sort such as listed
21 above but certainly not limited to that list– physician or not- in the event of a disagreement
22 between an administrator and the attending physician regarding a decision one would call a
23 mere judgment call, the onus would be on the administrator to prove to an ethics committee
24 why the attending physician is wrong prior to anyone having the authority to overturn or
25 overrule the order of the physician attending the patient directly (Directive to Take Action); and
26 be it further
27

28 RESOLVED, That our AMA reaffirm that the responsibility 1 for the care of the individual patient
29 lies with a prudent and responsible attending physician, and that his/her decisions should not
30 easily be overturned unless there has been an egregious and dangerous judgment error made,
31 and this would still call for an ethics committee consult in that instance (Reaffirm HOD Policy);
32 and be it further
33

34 RESOLVED, That our AMA aggressively pursue any encroachment of administrators upon the
35 medical decision making of attending physicians that is not in the best interest of patients a
36 strongly as possible, for there is no more sacred relationship than that of a doctor and his/her
37 patient, and as listed above, first, we do no harm. (Directive to Take Action)
38

39 Limited testimony was heard in support of the Resolution 009. Testimony was sympathetic to
40 the claim that hospitals have increasing power while physicians have decreasing power and this
41 discordance should be addressed. However, most testimony recommended referral because (i)
42 Resolve 2 demonstrated a misunderstanding of the role of ethics committees, (ii) Resolve 3
43 used inflammatory language but did not add to existing AMA policy on non-interference in the
44 patient-physician relationship and (iii) in general the tone and wording of the resolution could be
45 improved. Your Reference Committee agreed with this rationale and recommends Resolution
46 009 for referral for report.
47
48

1 (20) RESOLUTION 011 - ADVOCATING FOR THE
2 INFORMED CONSENT FOR ACCESS TO
3 TRANSGENDER HEALTH CARE
4

5
6 **RECOMMENDATION:**

7
8 **Resolution 011 be referred.**

9
10 **HOD ACTION: Resolution 011 referred**

11
12 RESOLVED, That our American Medical Association advocate and encourage the adoption of
13 an informed consent model when determining coverage for transgender health care services.
14 (Directive to Take Action)

15
16 The majority of testimony supported referral on the basis that Resolution 011 addresses a
17 complex issue. Additional time is needed to address new standards, work with insurers and
18 explore any legal implications of changing practice guidelines. It was generally agreed that the
19 mental health assessment can be a barrier to obtaining care and this should be recognized in
20 new policy. Your Reference Committee agreed that this requires further study and recommends
21 Resolution 011 for referral with report back.
22
23
24
25
26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee B

Hillary Johnson-Jahangir, MD, PhD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

3 RECOMMENDED FOR ADOPTION

- 2
- 3
- 4
- 5 1. Resolution 202 – Advocating for State GME Funding
- 6 2. Resolution 210 – Elimination of Seasonal Time Changes and Establishment of
- 7 Permanent Standard Time
- 8 3. Resolution 211 – Illicit Drug Use Harm Reduction Strategies
- 9 4. Resolution 222 – Allocate Opioid Funds to Train More Addiction Treatment
- 10 Physicians
- 11 5. Resolution 230 – Increased Health Privacy on Mobile Apps in Light of Roe v.
- 12 Wade
- 13
- 14

15 RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

- 16
- 17 6. Resolution 201 – Physician Reimbursement for Interpreter Services
- 18 7. Resolution 203 – International Medical Graduate Employment
- 19 8. Resolution 205 – Waiver of Due Process Clauses
- 20 9. Resolution 206 – The Shortage of Bedside Nurses and Intersection with
- 21 Concerns in Nurse Practitioner Training
- 22 10. Resolution 215 – Eliminating Practice Barriers for Immigrant Physicians During
- 23 Public Health Emergencies
- 24 11. Resolution 216 – Expanding Parity Protections and Coverage of Mental Health
- 25 and Substance Use Disorder Care in Medicare
- 26 12. Resolution 219 – Hold Accountable the Regulatory Bodies, Hospital Systems,
- 27 Staffing Organizations, Medical Staff Groups, and Individual Physicians
- 28 Supporting Systems of Care Promoting Direct Supervision of Emergency
- 29 Departments by Nurse Practitioners
- 30 13. Resolution 223 – Criminalization of Pregnancy Loss as the Result of Cancer
- 31 Treatment
- 32 14. Resolution 224 – Fertility Preservation
- 33 15. Resolution 227 – Access to Methotrexate Based on Clinical Decisions
- 34 16. Resolution 228 – Requirements for Physician Self-reporting of Outpatient Mental
- 35 Health Services, Treatments or Medications to Credentialing Agencies and
- 36 Insurers

- 1 17. Resolution 233 (Late Resolution 1001) – Urgent AMA Assistance to Puerto Rico
2 and Florida and a Long-Range Project for Puerto Rico
3

4 **RECOMMENDED FOR REFERRAL**
5

- 6 18. Resolution 214 – Universal Good Samaritan Statute
7 19. Resolution 232 – Obtaining Professional Recognition for Medical Service
8 Professionals
9

10 **RECOMMENDED FOR ADOPTION IN LIEU OF**
11

- 12 20. Resolution 208 – Comparing Student Debt, Earnings, Work Hours, and Career
13 Satisfaction Metrics in Physicians v. Other Health Professionals
14 21. Resolution 229 – Coverage and Reimbursement for Abortion Services
15 Resolution 231 – Expanding Support for Access to Abortion Care
16

17 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**
18

- 19 22. Resolution 213 – Hazard Pay During a Disaster Emergency
20
21
22

RECOMMENDED FOR ADOPTION**(1) RESOLUTION 202 – ADVOCATING FOR STATE GME FUNDING****RECOMMENDATION:****Resolution 202 be adopted.****HOD ACTION: Resolution 202 adopted.**

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)

Your Reference Committee heard testimony largely in support of Resolution 202. Your Reference Committee heard that our AMA has extensive policy supporting additional funding for Graduate Medical Education from all sources, including state funding, as well as policy supporting funding of the public health workforce pipeline. Your Reference Committee understands that multiple reports have been written by our AMA on GME funding, including the [Compendium of Graduate Medical Education Initiatives](#) that is available on the AMA website and that our AMA's FREIDA resource allows medical students to search for existing residency programs, including state-funded programs. Your Reference Committee recognizes our existing policy and reports and commends our ongoing work; however, given the overwhelming testimony in support of Resolution 202, your Reference Committee recommends that Resolution 202 be adopted.

(2) RESOLUTION 210 – ELIMINATION OF SEASONAL TIME CHANGES AND ESTABLISHMENT OF PERMANENT STANDARD TIME**RECOMMENDATION:****Resolution 210 be adopted.****HOD ACTION: Resolution 210 adopted.**

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)

Your Reference Committee heard mostly positive testimony in favor of adopting Resolution 210. Your Reference Committee heard that the issue of whether the U.S. should continue to adhere to seasonal time changes or instead switch to permanent Daylight Savings Time (DTS) or Standard Time (ST) had proponents on both sides. Your Reference Committee further heard that the American Academy of Sleep Medicine supports eliminating seasonal time changes and establishing year-round ST due to the health benefits associated with standard time and its relation to the body's natural

1 circadian rhythm. However, your Reference Committee heard that the U.S. Senate
2 recently passed bipartisan legislation that would make DST permanent across the
3 country and an identical U.S. House of Representatives bill is pending. It is unclear
4 whether the U.S. House of Representatives bill will be considered before the end of the
5 current Congress. Testimony was also heard that establishing policy in favor of
6 permanent Standard Time now would allow our AMA to support Standard Time
7 legislation that may be considered in the future. Therefore, your Reference Committee
8 recommends that Resolution 210 be adopted.

9
10 (3) RESOLUTION 211 – ILLICIT DRUG USE HARM
11 REDUCTION STRATEGIES

12
13 **RECOMMENDATION A:**

14
15 **Resolution 211 be adopted.**

16
17 **RECOMMENDATION B:**

18
19 **AMA Policy H-95.989 be rescinded.**

20
21 **HOD ACTION: Resolution 211 adopted with a change of**
22 **title and AMA Policy H-95.989 rescinded.**

23
24 **SUBSTANCE USE HARM REDUCTION**

25
26 RESOLVED, That our American Medical Association amend current policy D-95.987,
27 "Prevention of Drug-Related Overdose," by addition to read as follows:

28
29 4. Our AMA will advocate for and encourage state and county medical societies to
30 advocate for harm reduction policies that provide civil and criminal immunity for the
31 possession, distribution, and use of "drug paraphernalia" designed for harm reduction
32 from drug use, including but not limited to drug contamination testing and injection drug
33 preparation, use, and disposal supplies.

34
35 5. Our AMA will implement an education program for patients with substance use
36 disorder and their family/caregivers to increase understanding of the increased risk of
37 adverse outcomes associated with having a substance use disorder and a serious
38 respiratory illness such as COVID-19.

39
40 6. Our AMA supports efforts to increase access to fentanyl test strips and other drug
41 checking supplies for purposes of harm reduction. (Modify Current HOD Policy)

42
43 Your Reference Committee heard sobering testimony that the nation's overdose
44 epidemic now is killing more than 100,000 people in the United States every year and,
45 tragically, the deaths and harms are ever-increasing. Your Reference Committee agrees
46 with testimony that harm reduction and treatment for substance use disorders are
47 needed to end the epidemic. Testimony highlighted that we are at a point in the nation's
48 overdose epidemic where we truly need to focus on doing everything possible to keep
49 people alive and that harm reduction efforts, whether naloxone, syringe services
50 programs, overdose prevention sites, and fentanyl test strips are among those measures

1 designed to keep people alive. Your Reference Committee heard testimony that these
2 measures are evidence-based, reasonable public health steps that should be
3 encouraged. Testimony also highlighted that our House of Delegates and our AMA has,
4 for the past several years, advanced many policies in support of harm reduction and
5 decriminalization of public health efforts. Your Reference Committee was not presented
6 with sufficient information to properly evaluate all potential harm reduction initiatives, but
7 notes that, based on testimony received, there is strong evidence and broad support
8 among state and federal policymakers for increasing access to, and decriminalizing
9 possession and use of, fentanyl test strips and other drug checking supplies. Your
10 Reference Committee also heard that our AMA has outdated policy (Policy H-95.989 -
11 Drug Paraphernalia) that conflicts with more recent AMA policy and advocacy activities
12 and agrees with testimony recommending that it be rescinded. Therefore, your
13 Reference Committee recommends that Resolution 211 be adopted, and that Policy H-
14 95.989 be rescinded.

15
16 **Drug Paraphernalia H-95.989**

17 The AMA opposes the manufacture, sale and use of drug paraphernalia.

- 18
19 (4) RESOLUTION 222 – ALLOCATE OPIOID FUNDS TO
20 TRAIN MORE ADDICTION TREATMENT PHYSICIANS

21
22 **RECOMMENDATION:**

23
24 **Resolution 222 be adopted.**

25
26 **HOD ACTION: Resolution 222 adopted.**

27
28 RESOLVED, That our American Medical Association amend Policy H-95.918, "Holding
29 the Pharmaceutical Industry Accountable for Opioid-Related Costs," by addition to read
30 as follows:

31
32 Our AMA will advocate that any monies paid to the states, received as a result of a
33 settlement or judgment, or other financial arrangement or agreement as a result of
34 litigation against pharmaceutical manufacturers, distributors, or other entities alleged to
35 have engaged in unethical and deceptive misbranding, marketing, and advocacy of
36 opioids, be used exclusively for research, education, prevention, and treatment of
37 overdose, opioid use disorder, and pain, as well as expanding physician training
38 opportunities to provide clinical experience in the treatment of opioid use disorders.
39 (Modify Current HOD Policy)

40
41 Your Reference Committee heard supportive testimony for Resolution 222. Your
42 Reference Committee agrees that current treatment resources are insufficient to
43 effectively address treatment needs for individuals with a substance use disorder.
44 Testimony stated that our AMA has been active in state and national policy initiatives to
45 advocate that any monies paid to the states, received as a result of a settlement or
46 judgment, or other financial arrangement or agreement as a result of litigation against
47 pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in
48 unethical and deceptive misbranding, marketing, and advocacy of opioids, be used
49 exclusively for research, education, prevention, and treatment of overdose, opioid use
50 disorder, and pain. Testimony also highlighted that our AMA advocacy has included

1 working directly with the Johns Hopkins School of Public Health and more than 50 other
2 patient and medical stakeholders in support of current AMA policy (See [Principles for the](#)
3 [Use of Opioid Litigation Funds](#)). Your Reference Committee heard that AMA advocacy
4 currently calls for undergraduate and graduate medical education and training programs
5 to hire core faculty in addiction medicine, psychiatry, and pain management to support
6 increasing the physician workforce in these areas. Your Reference Committee agrees
7 that education and training include, but should not be limited to, clinical exposure.
8 Testimony highlighted that medical schools and residency programs would benefit
9 greatly from increasing core curricula in addiction treatment for all specialties. Testimony
10 stated that it is very difficult to build an effective addiction medicine and psychiatry
11 workforce without having a sufficient number of addiction medicine and psychiatry
12 faculty. Therefore, your Reference Committee recommends that Resolution 222 be
13 adopted.

14
15 (5) RESOLUTION 230 - INCREASED HEALTH PRIVACY ON
16 MOBILE APPS IN LIGHT OF ROE V. WADE

17
18 **RECOMMENDATION:**

19
20 **Resolution 230 be adopted.**

21
22 **HOD ACTION: Resolution 230 adopted.**

23
24 RESOLVED, That AMA policy D-315.968 be amended by addition as follows:

25
26 **Supporting Improvement to Patient Data Privacy D-315.968**

27 Our AMA will (1) strengthen patient and physician data privacy protections by advocating
28 for legislation that reflects the AMA's Privacy Principles with particular focus on mobile
29 health apps and other digital health tools, in addition to non-health apps and software
30 capable of generating patient data and (2) will work with appropriate stakeholders to
31 oppose using any personally identifiable data to identify patients, potential patients who
32 have yet to seek care, physicians, and any other healthcare providers who are providing
33 or receiving healthcare that may be criminalized in a given jurisdiction.

34
35 Your Reference Committee heard testimony mostly in support of Resolution 230. Your
36 Reference Committee heard that Resolution 230 already aligns with current AMA policy
37 and advocacy work including our AMA's Privacy Principles. Testimony highlighted that
38 Policy D.315-968 already directs our AMA to strengthen patient data privacy protections
39 by advocating for legislation that reflects our AMA's Privacy Principles with particular
40 focus on mobile health apps and other digital health tools. Testimony also stated that it is
41 important to ensure that, as the privacy landscape continues to evolve with sensitive
42 overlays, such as reproductive health, it is important that our policy evolves, and part of
43 that evolution is specifically mentioning the importance of covering the privacy rights of
44 all individuals regardless of the modality used to share information, including apps.
45 Therefore, your Reference Committee recommends Resolution 230 be adopted.
46

1 RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**2**
3 (6) RESOLUTION 201 – PHYSICIAN REIMBURSEMENT
4 FOR INTERPRETER SERVICES
5**6 RECOMMENDATION A:****7 The first Resolve of Resolution 201 be amended by**
8 addition to read as follows:
9**10 RESOLVED, That our American Medical Association**
11 prioritize physician reimbursement for interpreter
12 services, including American Sign Language, and
13 advocate for legislative and/or regulatory changes to
14 federal health care programs such as Medicare,
15 Medicare Advantage plans, Tricare, Veterans
16 Administration, etc., for payment for such services
17 (Directive to Take Action); and be it further
18**19 RECOMMENDATION B:****20 The second Resolve of Resolution 201 be amended by**
21 addition and deletion to read as follows:
22**23 RESOLVED, That our AMA ~~develop model state~~**
24 legislation continue to work with interested state and
25 specialty societies to advocate for physician
26 reimbursement for interpreter services, including
27 American Sign Language, for commercial health plans,
28 workers' compensation plans, Medicaid, Medicaid
29 managed care plans, etc., for payment for such
30 services. (Directive to Take Action).
31**32 RECOMMENDATION C:****33**
34 Resolution 201 be adopted as amended.
35**36 HOD ACTION: Resolution 201 adopted as amended.**
37**38 RESOLVED, That our American Medical Association prioritize physician reimbursement**
39 for interpreter services and advocate for legislative and/or regulatory changes to federal
40 health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans
41 Administration, etc., for payment for such services (Directive to Take Action); and be it
42 further
43**44 RESOLVED, That our AMA develop model state legislation for physician reimbursement**
45 for interpreter services for commercial health plans, worker compensation plans,
46 Medicaid, Medicaid managed care plans, etc., for payment for such services. (Directive
47 to Take Action)
48

1 Your Reference Committee heard robust testimony in support of physician
2 reimbursement for interpreter services. Testimony stated that our AMA already supports
3 access to quality care for all individuals and encourages physicians to make their offices
4 accessible to Limited English Proficiency (LEP) individuals and those who rely on
5 auxiliary aids and services. Testimony also stated that our AMA believes that the
6 financial burden of medical interpretive services and translation should not fall on
7 physician practices. Testimony noted that our AMA already advocates in these areas on
8 many fronts and further stated that this advocacy stems from the extensive policy
9 adopted by our House of Delegates, including Certified Translation and Interpreter
10 Services D-385.957, which would apply to physician reimbursement for interpreter
11 services and advocacy for legislation to support reimbursement for these services.
12 Moreover, your Reference Committee heard extensive testimony on the work our AMA is
13 already doing at the state level. An amendment was offered that stated the importance
14 of ensuring that our policy specifically addresses individuals who are hearing impaired
15 by specifically including access to sign language interpreters in our policy. Your
16 Reference Committee agrees with the proffered amendment and, therefore,
17 recommends that Resolution 201 be adopted as amended.

18
19 (7) RESOLUTION 203 – INTERNATIONAL MEDICAL
20 GRADUATE EMPLOYMENT

21
22 **RECOMMENDATION A:**

23
24 **Resolution 203 be amended by addition and deletion**
25 **to read as follows:**

26
27 **RESOLVED, That our American Medical Association**
28 **support federal legislation that reduces the paperwork**
29 **administrative burden on and streamlines the process**
30 **of hiring of International Medical Graduates in rural**
31 **communities. (New HOD Policy)**

32
33 **RECOMMENDATION B:**

34
35 **Resolution 203 be adopted as amended.**

36
37 **HOD ACTION: Resolution 203 adopted as amended.**

38
39 RESOLVED, That our American Medical Association support federal legislation that
40 reduces the paperwork burden on hiring of International Medical Graduates in rural
41 communities. (New HOD Policy)

42
43 Your Reference Committee heard positive testimony on Resolution 203. Your Reference
44 Committee heard that international medical graduates (IMGs) play a crucial role in
45 providing care in underserved communities in the U.S. Testimony highlighted that IMGs
46 disproportionately serve in rural and underserved communities but that the paperwork to
47 hire and maintain these individuals is extremely burdensome and deters small rural
48 practices from being able to hire these physicians, even though the need for them is
49 great. Testimony also stated that our AMA is currently advocating for the smoother
50 passage of IMGs through the immigration system and that this resolution would

1 complement our existing work. Some testimony did note that the use of the word
2 “paperwork” within the original resolution is ambiguous and should be removed, since all
3 physicians experience paperwork burdens. Moreover, your Reference Committee heard
4 that IMGs, regardless of whether or not they serve in rural communities, face
5 administrative burdens when being hired and maintaining a valid visa. Therefore, your
6 Reference Committee recommends that Resolution 203 be adopted as amended.

7
8 (8) RESOLUTION 205 – WAIVER OF DUE PROCESS
9 CLAUSES

10
11 **RECOMMENDATION A:**

12
13 **Resolution 205 be amended by addition and deletion**
14 **to read as follows:**

15
16 **RESOLVED, That our American Medical Association**
17 **support legislation that bans the use of “Waiver of Due**
18 **Process” provisions within physician employment**
19 **contracts and declares such current provisions to be**
20 **declared void. (New HOD Policy)**

21
22 **RECOMMENDATION B:**

23
24 **Resolution 205 be adopted as amended.**

25
26 **HOD ACTION: Resolution 205 adopted as amended.**

27
28 RESOLVED, That our American Medical Association support legislation that bans the
29 use of “Waiver of Due Process” provisions within employment contracts and declares
30 such current provisions to be declared void. (New HOD Policy)

31
32 Your Reference Committee heard unanimous testimony in favor of adopting Resolution
33 205. Testimony indicated the need to ensure that physicians are entitled to full due
34 process protections regardless of employer, and that our AMA should advocate strongly
35 against any contract language that would waive those protections. Your Reference
36 Committee heard testimony that our AMA is already developing legislation that prohibits
37 and voids any such waiver language, and this model legislation will be available to all
38 members of the Federation of Medicine when finalized. Testimony highlighted that our
39 AMA will continue to support advocacy efforts and develop resources that support the
40 rights of employed physicians. Your Reference Committee considered an amendment
41 on collecting information concerning employed physician contracts; however, there was
42 no further testimony in support of this amendment and your Reference Committee
43 believes it departs from the original intent of the resolution. Two friendly amendments
44 were offered to specify that our AMA support legislation concerning physician
45 employment contracts. Therefore, your Reference Committee recommends that
46 Resolution 205 be adopted as amended.

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2
3
4 (9) RESOLUTION 206 – THE SHORTAGE OF BEDSIDE
5 NURSES AND INTERSECTION WITH CONCERNS IN
6 NURSE PRACTITIONER TRAINING

7
8 **RECOMMENDATION A:**

9
10 **The first Resolve of Resolution 206 be amended by**
11 **addition and deletion to read as follows:**

12
13 **RESOLVED, That our American Medical Association**
14 **~~study, and encourage relevant advocacy organizations~~**
15 **~~to study, the links between the bedside nursing~~**
16 **~~shortage, expansion of nurse practitioner programs,~~**
17 **~~and the impact of this connection on patient health~~**
18 **outcomes review existing literature on the nursing**
19 **workforce shortage, including the impact of increased**
20 **enrollment in nurse practitioner programs (Directive to**
21 **Take Action); and be it further**

22
23 **RECOMMENDATION B:**

24
25 **Resolution 206 be adopted as amended.**

26
27 **RECOMMENDATION C:**

28
29 **The title of Resolution 206 be changed to read as**
30 **follows:**

31
32 **NURSING SHORTAGE**

33
34 **HOD ACTION: Resolution 206 adopted as amended with a**
35 **change of title.**

36
37 **NURSING SHORTAGE**

38
39 **RESOLVED, That our American Medical Association study, and encourage relevant**
40 **advocacy organizations to study, the links between the bedside nursing shortage,**
41 **expansion of nurse practitioner programs, and the impact of this connection on patient**
42 **health outcomes (Directive to Take Action); and be it further**

43
44 **RESOLVED, That our AMA reaffirm existing policies H-160.947, Physician Assistants**
45 **and Nurse Practitioners, and H-35.996, Status and Utilization of New or Expanding**
46 **Health Professionals in Hospitals. (Reaffirm HOD Policy)**

47
48 **Your Reference Committee heard mixed testimony regarding Resolution 206. Your**
49 **Reference Committee heard that the study as proposed in Resolution 206 is not possible**
50 **due to a lack of available relevant data and because a causal connection cannot be**

1 drawn between the nursing shortage/nurse practitioner programs and patient health
2 outcomes. Many also testified that it would be more appropriate for nursing
3 organizations to study this topic and expressed a general concern with how information
4 from such a study would be used. Your Reference Committee received a proposed
5 amendment that would require our AMA to conduct a review of existing literature on this
6 topic, instead of designing and executing a novel study. Your Reference Committee
7 heard testimony largely in support of this amendment. Based on the testimony, and
8 because existing literature may shed light on the issue brought forth in the Resolution,
9 your Reference Committee recommends that Resolution 206 be adopted as amended.

10
11 (10) RESOLUTION 215 – ELIMINATING PRACTICE
12 BARRIERS FOR IMMIGRANT PHYSICIANS DURING
13 PUBLIC HEALTH EMERGENCIES
14

15 **RECOMMENDATION A:**

16
17 **The first Resolve of Resolution 215 be amended by**
18 **addition and deletion to read as follows:**
19

20 **RESOLVED, That our American Medical Association**
21 **advocate ~~advise the state medical boards and other~~**
22 **stakeholders to allow currently practicing physicians,**
23 **including international medical graduates, with valid**
24 **licenses in states and territories of the U.S. in the**
25 **health professional shortage areas to have temporary**
26 **access to all unique and expedited licensing options,**
27 **both inside and outside of the state of their practice**
28 **during public health emergencies, to facilitate**
29 **workforce utilization at the time of critical shortage**
30 **(Directive to Take Action); and be it further**
31

32 **RECOMMENDATION B:**

33
34 **The second Resolve of Resolution 215 be deleted.**
35

36 **~~RESOLVED, That our AMA advocate at the state and~~**
37 **~~national level and advise the Department of Labor and~~**
38 **~~the Department of Homeland Security to allow~~**
39 **~~temporary provisions for such licensing inclusions for~~**
40 **~~the physicians on a Visa during public health~~**
41 **~~emergencies. (Directive to Take Action)~~**
42

43 **RECOMMENDATION C:**

44
45 **Resolution 215 be adopted as amended.**
46
47

1 **RECOMMENDATION D:**

2
3 **The title of Resolution 215 be changed to read as**
4 **follows:**

5
6 **ELIMINATING PRACTICE BARRIERS FOR INTERNATIONAL MEDICAL**
7 **GRADUATE PHYSICIANS DURING PUBLIC HEALTH EMERGENCIES**

8
9 **HOD ACTION: Resolution 215 be adopted as amended with**
10 **a change of title.**

11
12 **ELIMINATING PRACTICE BARRIERS FOR**
13 **INTERNATIONAL MEDICAL GRADUATE PHYSICIANS**
14 **DURING PUBLIC HEALTH EMERGENCIES**

15
16 RESOLVED, That our American Medical Association advise the state medical boards
17 and other stakeholders to allow physicians in the health professional shortage areas to
18 have temporary access to all unique and expedited licensing options, both inside and
19 outside of the state of their practice during public health emergencies, to facilitate
20 workforce utilization at the time of critical shortage (Directive to Take Action); and be it
21 further

22
23 RESOLVED, That our AMA advocate at the state and national level and advise the
24 Department of Labor and the Department of Homeland Security to allow temporary
25 provisions for such licensing inclusions for the physicians on a Visa during public health
26 emergencies. (Directive to Take Action)

27
28 Your Reference Committee heard mixed testimony on Resolution 215. Testimony stated
29 that it is important to ensure that physicians can practice in areas where an emergency
30 occurs regardless of licensure and as such, there should be expedient pathways for
31 these individuals to gain temporary licensure to aid in times of need. Your Reference
32 Committee heard that international medical graduates (IMGs) are an important part of
33 our health care system and should be allowed to offer care to patients when there is a
34 public health emergency. Moreover, your Reference Committee heard that if the MD/DO
35 who is licensed is an IMG that wants to aid individuals in an emergency they are covered
36 by our current advocacy, our policy does not differentiate or exclude these individuals
37 from our advocacy to help ensure that physicians can go where needed in an
38 emergency. In line with this policy, testimony stated that during COVID our AMA
39 advocated for expedited processing times, lower burdens for location condition
40 applications, extended visa times, and more for our IMGs. Your Reference Committee
41 also heard that our AMA does not support expedited licensure for individuals that are not
42 licensed due to the education and safety standards needed to ensure that patients
43 receive the best care possible, especially those in a declared emergency. Your
44 Reference Committee also heard considerable testimony that it was not the intent of the
45 Resolution's authors to provide IMGs with an alternate licensing pathway if they are not
46 already licensed, but instead to allow already licensed IMGs to be able to travel to, and
47 help during, emergencies without the restrictions that their visas normally place upon
48 them, such as the inability for an H-1B to work in any other location or in an any other
49 capacity besides the one specifically listed on their visa. Your Reference Committee
50 received an amendment clarifying this intent from the Resolution's authors and the

1 amendment received support from numerous individuals. In addition, to limit redundancy
2 and expand our AMA advocacy the second resolve was struck. Since your Reference
3 Committee supports the proffered amendment we have altered the title of the Resolution
4 to better reflect the amended language. Therefore, your Reference Committee
5 recommends that Resolution 215 be adopted as amended.
6

7 (11) RESOLUTION 216 – EXPANDING PARITY
8 PROTECTIONS AND COVERAGE OF MENTAL HEALTH
9 AND SUBSTANCE USE DISORDER CARE IN
10 MEDICARE
11

12 **RECOMMENDATION A:**
13

14 **Subpoint 2 of Resolution 216 be amended by addition**
15 **to read as follows:**
16

17 **2. Our AMA supports federal legislation, standards,**
18 **policies, and funding that enforce and expand the**
19 **parity and non-discrimination protections of the Paul**
20 **Wellstone and Peter Domenici Mental Health Parity**
21 **and Addiction Equity Act of 2008 to Medicare (Parts A,**
22 **B, C and D).**
23

24 **RECOMMENDATION B:**
25

26 **Resolution 216 be amended by addition of a new**
27 **resolve clause to read as follows:**
28

29 **RESOLVED, Our AMA support requirements of all**
30 **health insurance plans to implement a compliance**
31 **program to demonstrate compliance with state and**
32 **federal mental health parity laws.**
33

34 **RECOMMENDATION C:**
35

36 **Resolution 216 be adopted as amended.**
37

38 **RECOMMENDATION D:**
39

40 **The title of Resolution 216 be changed to read as**
41 **follows:**
42

43 **EXPANDING PARITY PROTECTIONS AND COVERAGE**
44 **OF MENTAL HEALTH AND SUBSTANCE USE**
45 **DISORDER CARE**
46

47 **HOD ACTION: Resolution 216 be adopted as amended with**
48 **a change of title.**
49

1 **EXPANDING PARITY PROTECTIONS AND COVERAGE**
2 **OF MENTAL HEALTH AND SUBSTANCE USE**
3 **DISORDER CARE**

4
5 RESOLVED, That our American Medical Association amend policy H-185.974, "Parity
6 for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs," by
7 addition and deletion to read as follows:

8
9 Parity for Mental ~~Illness~~ Health, ~~Alcoholism~~, and ~~Related~~ Substance Use Disorders in
10 Health Insurance ~~Medical Benefits~~ Programs H-185.974

11
12 1. Our AMA supports parity of coverage for mental ~~illness~~, ~~alcoholism~~, health, and
13 ~~substance use~~, ~~and eating~~ disorders.

14
15 2. Our AMA supports federal legislation, standards, policies, and funding that expand the
16 parity and non-discrimination protections of the Paul Wellstone and Peter Domenici
17 Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C, and
18 D).

19
20 3. Our AMA supports federal legislation, standards, policies, and funding that require
21 Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance
22 use disorder care, consistent with nationally recognized medical professional
23 organization level of care criteria for mental health or substance use disorders. (Modify
24 Current HOD Policy)

25
26 Your Reference Committee heard strong support for Resolution 216. Your Reference
27 Committee agrees that more needs to be done to support—and enforce—strong patient
28 protections with respect to mental health and substance use disorder parity. Testimony
29 highlighted that our colleagues from across the Federation of Medicine have worked
30 assiduously to strengthen state and federal mental health and substance use disorder
31 parity laws. Your Reference Committee agrees with testimony that since the Mental
32 Health Parity and Addiction Equity Act was enacted in 2008, health insurance
33 companies have often violated the law. Testimony stated that parity protections should
34 extend to Medicare. Your Reference Committee also heard that while there are strong
35 policies in state and federal law, those policies must be strongly enforced. As such, your
36 Reference Committee agrees with a proffered amendment that would add the word
37 enforcement to the Resolution. Your Reference Committee, furthermore, agrees with an
38 additional offered amendment, that would have our AMA support requirements that
39 health insurers demonstrate compliance with parity laws as a regular matter of doing
40 business and encourage state and federal regulators to take advantage of current laws
41 that require health insurers to prove they are in compliance with parity laws as a
42 condition of doing business. Therefore, your Reference Committee recommends that
43 Resolution 216 be adopted as amended.

44
45

1 (12) RESOLUTION 219 – HOLD ACCOUNTABLE THE
2 REGULATORY BODIES, HOSPITAL SYSTEMS,
3 STAFFING ORGANIZATIONS, MEDICAL STAFF
4 GROUPS, AND INDIVIDUAL PHYSICIANS SUPPORTING
5 SYSTEMS OF CARE PROMOTING DIRECT
6 SUPERVISION OF EMERGENCY DEPARTMENTS BY
7 NURSE PRACTITIONERS
8

9 **RECOMMENDATION A:**

10
11 **Resolution 219 be amended by addition and deletion**
12 **to read as follows:**

13
14 **~~RESOLVED, That, in accordance with Centers for~~**
15 **~~Medicare & Medical Services regulations and~~**
16 **~~standards of practice for emergency medicine as~~**
17 **~~defined by ACEP and AAEM, our American Medical~~**
18 **~~Association hold accountable the regulatory bodies,~~**
19 **~~hospital systems, staffing organizations, medical staff~~**
20 **~~groups, and individual physicians supporting systems~~**
21 **~~of care that promote direct supervision of emergency~~**
22 **~~departments by nurse practitioners advocate that~~**
23 **physicians, ideally board certified emergency**
24 **physicians, are the only members of the health care**
25 **team qualified to supervise the provision of**
26 **emergency care services in the emergency**
27 **department. (New HOD Policy)**
28

29 **RECOMMENDATION B:**

30
31 **Resolution 219 be adopted as amended.**
32

33 **RECOMMENDATION C:**

34
35 **The title of Resolution 219 be changed to read as**
36 **follows:**
37

38 **PROMOTING DIRECT SUPERVISION OF EMERGENCY DEPARTMENTS BY**
39 **PHYSICIANS**

40
41 **HOD ACTION: Resolution 219 be referred for decision.**
42

43 **RESOLVED, That, in accordance with Centers for Medicare & Medical Services**
44 **regulations and standards of practice for emergency medicine as defined by ACEP and**
45 **AAEM, our American Medical Association hold accountable the regulatory bodies,**
46 **hospital systems, staffing organizations, medical staff groups, and individual physicians**
47 **supporting systems of care that promote direct supervision of emergency departments**
48 **by nurse practitioners. (New HOD Policy)**
49

1 Your Reference Committee heard testimony generally in favor of the spirit of Resolution
2 219. Your Reference Committee heard ample testimony indicating that direct supervision
3 of emergency departments (EDs) by nurse practitioners (NPs) and other non-physicians
4 puts patients at risk and cuts against existing AMA policy that supports physician-led
5 care. Your Reference Committee also heard that the Resolution may be unsuitable for
6 adoption as proposed. Your Reference Committee heard multiple concerns with the
7 “hold accountable” language noting that our AMA does not enforce law or policy.
8 Moreover, your Reference Committee heard that, as written, the policy inadvisably
9 references policy of external organizations and references CMS regulations that do not
10 clearly establish that NPs may not supervise Emergency Departments. Your Reference
11 Committee heard several proposed amendments, including an amendment that would
12 retain the driving principle behind Resolution 219 by calling upon our AMA to advocate
13 that only physicians may supervise emergency care in an emergency department, in
14 alignment with existing AMA policy and with the policies of the organizations referenced
15 in the Resolution. Testimony generally supported the proposed amendment, including
16 testimony from the American College of Emergency Physicians which supported the
17 amendment and recommended additional language that physicians who supervise
18 emergency departments ideally should be board certified in emergency medicine. Your
19 Reference Committee also heard calls to expand the resolution to include other facilities
20 such as urgent care centers and orthopedic surgery centers. Your Reference Committee
21 considered such testimony and opted to honor the intent of the original resolution by
22 limiting the focus to care provided in an emergency department, recognizing that
23 abundant existing AMA policy and robust advocacy at the state and federal level
24 supporting physician-led care covers the issue more broadly. Therefore, your Reference
25 Committee changed the title of the Resolution to better reflect the content of the
26 amended resolution. As such, Your Reference Committee recommends that Resolution
27 219 be adopted as amended.

28
29 (13) RESOLUTION 223 – CRIMINALIZATION OF
30 PREGNANCY LOSS AS THE RESULT OF CANCER
31 TREATMENT

32
33 **RECOMMENDATION A:**

34 **Resolve 1 of Resolution 223 be amended by addition**
35 **and deletion to read as follows:**

36
37 **RESOLVED, That our American Medical Association**
38 **advocate that pregnancy loss ~~as a result of medically~~**
39 **~~necessary treatment for cancer~~ shall not be**
40 **criminalized for physicians or pregnant patients**
41 **(Directive to Take Action); and**
42

1 **RECOMMENDATION B:**

2
3 **Resolve 2 of Resolution 223 be amended by addition**
4 **and deletion to read as follows:**

5
6 **RESOLVED, That our AMA advocate that physicians**
7 **and patients should not be held civilly and/or**
8 **criminally liable for pregnancy loss as a result of**
9 **medically necessary care ~~treatment for cancer.~~**
10 **(Directive to Take Action)**

11
12 **RECOMMENDATION C:**

13
14 **Resolution 223 be adopted as amended.**

15
16 **RECOMMENDATION D:**

17
18 **The title of Resolution 223 be changed to read as**
19 **follows:**

20
21 **CRIMINALIZATION OF AND CIVIL LIABILITY FOR**
22 **PREGNANCY LOSS AS THE RESULT OF MEDICALLY**
23 **NECESSARY CARE**

24
25 **HOD ACTION: Resolution 223 be adopted as amended with**
26 **a change of title.**

27
28 **OPPOSITION TO CRIMINALIZATION OF AND CIVIL**
29 **LIABILITY FOR PREGNANCY LOSS AS THE RESULT OF**
30 **MEDICALLY NECESSARY CARE**

31
32 RESOLVED, That our American Medical Association advocate that pregnancy loss as a
33 result of medically necessary treatment for cancer shall not be criminalized for
34 physicians or patients (Directive to Take Action); and

35
36 RESOLVED, That our AMA advocate that physicians should not be held civilly liable for
37 pregnancy loss as a result of treatment for cancer. (Directive to Take Action)

38
39 Your Reference Committee heard unanimous testimony in support of the intention of
40 Resolution 223. Testimony agreed that pregnancy loss as the result of medical care
41 should not result in liability for physicians or patients. However, testimony was split as to
42 whether it is appropriate to single out cancer treatment or whether the resolution should
43 be broader. Your Reference Committee heard testimony shift towards supporting the
44 inclusion of language that supports advocacy for broader medically necessary care. An
45 amendment was offered to apply the resolution to all medically necessary care and to
46 oppose criminal as well as civil liability for pregnancy loss. Significant support was heard
47 for this amendment. Your Reference Committee agrees with the testimony supporting
48 the amended language and altered the title of the resolution to better reflect the content
49 of the amended language. Therefore, your Reference Committee recommends that
50 Resolution 223 be adopted as amended.

1
2 (14) RESOLUTION 224 – FERTILITY PRESERVATION
3

4 **RECOMMENDATION A:**

5
6 **Subpoint 1 of AMA Policy H-185.990 be amended by**
7 **addition and deletion to read as follows:**
8

9 **1. Our AMA ~~encourages~~ advocate for third party payer**
10 **health insurance carriers to make available insurance**
11 **benefits for the diagnosis and treatment of recognized**
12 **male and female infertility.**
13

14 **RECOMMENDATION B:**

15
16 **Subpoint 2 of AMA Policy H-185.990 be amended by**
17 **addition and deletion to read as follows:**
18

19 **2. Our AMA ~~supports~~ advocates for payment for**
20 **fertility preservation therapy services by all payers**
21 **when iatrogenic infertility may be caused directly or**
22 **indirectly by necessary medical treatments as**
23 **determined by a licensed physician, and will ~~lobby for~~**
24 **appropriate support state and federal legislation**
25 **requiring payment for fertility preservation therapy**
26 **services by all payers when iatrogenic infertility may**
27 **be caused directly or indirectly by necessary medical**
28 **treatments as determined by a licensed physician,**
29 **including but not limited to cryopreservation of**
30 **embryos, sperm, oocytes, and ovarian and testicular**
31 **tissue.**
32

33 **RECOMMENDATION C:**

34
35 **Subpoint 3 of AMA Policy H-185.990 be amended by**
36 **addition and deletion to read as follows:**
37

38 **3. Our AMA ~~encourages~~ advocates for the inclusion of**
39 **impaired fertility as a consequence of gender-affirming**
40 **hormone therapy and gender-affirming surgery within**
41 **legislative definitions of iatrogenic infertility, and**
42 **supports access to fertility preservation services for**
43 **those affected.**
44

45 **RECOMMENDATION D:**

46
47 **AMA Policy H-185.990 be adopted as amended in lieu**
48 **of Resolution 224.**
49

RECOMMENDATION E:

That the following HOD policies be reaffirmed: D-5.999, Preserving Access to Reproductive Health Services, and H-160.946, The Criminalization of Health Care Decision Making

HOD ACTION: AMA Policy H-185.990 adopted as amended in lieu of Resolution 224 and AMA Policies D-5.999 and H-160.946 reaffirmed.

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)

Your Reference Committee heard testimony in support of coverage for payment for fertility preservation therapy services. An amendment was offered to add ovarian and testicular tissue cryopreservation to the definition of fertility preservation therapy services to ensure that individuals that need this additional care could access it regardless of their income status. Another amendment was offered to specify that advocacy for payment should target all private and public payers. Testimony was heard in opposition to the third resolve due to the fact that the third resolve clause singles out one clinical scenario. Testimony noted that our advocacy should not be constrained to one scenario, but rather should apply to a broader set of circumstances. Testimony also noted that the matters addressed by Resolution 224 are substantially addressed by existing policy and that amendment to existing policy would be preferable to new, separate policy. An amendment was offered to that end. Additionally, significant testimony highlighted the work that our AMA is already doing based on our current AMA policy and noted that it would be beneficial to reaffirm our existing relevant AMA policy. Therefore, your Reference Committee recommends that existing policy H-185.990 be adopted as amended in lieu of Resolution 224 and that existing AMA policies H-185.990, D-5.999, and H-160.946 be reaffirmed.

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will

1 lobby for appropriate federal legislation requiring payment for fertility preservation
2 therapy services by all payers when iatrogenic infertility may be caused directly
3 or indirectly by necessary medical treatments as determined by a licensed
4 physician.

5 3. Our AMA encourages the inclusion of impaired fertility as a consequence of
6 gender-affirming hormone therapy and gender-affirming surgery within legislative
7 definitions of iatrogenic infertility, and supports access to fertility preservation
8 services for those affected.

9

10 **Preserving Access to Reproductive Health Services D-5.999**

11

12 Our AMA: (1) recognizes that healthcare, including reproductive health services
13 like contraception and abortion, is a human right; (2) opposes limitations on
14 access to evidence-based reproductive health services, including fertility
15 treatments, contraception, and abortion; (3) will work with interested state
16 medical societies and medical specialty societies to vigorously advocate for
17 broad, equitable access to reproductive health services, including fertility
18 treatments, contraception, and abortion; (4) supports shared decision-making
19 between patients and their physicians regarding reproductive healthcare; (5)
20 opposes any effort to undermine the basic medical principle that clinical
21 assessments, such as viability of the pregnancy and safety of the pregnant
22 person, are determinations to be made only by healthcare professionals with
23 their patients; (6) opposes the imposition of criminal and civil penalties or other
24 retaliatory efforts against patients, patient advocates, physicians, other
25 healthcare workers, and health systems for receiving, assisting in, referring
26 patients to, or providing reproductive health services; (7) will advocate for legal
27 protections for patients who cross state lines to receive reproductive health
28 services, including contraception and abortion, or who receive medications for
29 contraception and abortion from across state lines, and legal protections for
30 those that provide, support, or refer patients to these services; and (8) will review
31 the AMA policy compendium and recommend policies which should be amended
32 or rescinded to reflect these core values, with report back at the 2022 Interim
33 Meeting.

34

35 **The Criminalization of Health Care Decision Making H-160.946**

36

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

47

1 (15) RESOLUTION 227 – ACCESS TO METHOTREXATE
2 BASED ON CLINICAL DECISIONS
3

4 **RECOMMENDATION A:**

5
6 **Resolve 1 of Resolution 227 be amended by addition**
7 **and deletion to read as follows:**
8

9 **RESOLVED, That our American Medical Association**
10 **oppose work to create a formal process to review**
11 **pharmaceutical practices related to refusal of**
12 **restrictions on prescribing, distributing, or dispensing**
13 **of methotrexate and other drugs on the basis that it**
14 **could be used off-label for pregnancy termination; and**
15 **be it further**
16

17 **RECOMMENDATION B:**

18
19 **Resolve 2 of Resolution 227 be amended by addition**
20 **and deletion to read as follows:**
21

22 **RESOLVED, That our AMA work with relevant**
23 **stakeholders to provide educational guidance on**
24 **state-specific laws, regulations, or other policies that**
25 **have impacted impede the prescribing, distributing, or**
26 **dispensing of methotrexate and other medications**
27 **because of their impact or perceived impact on a**
28 **pregnancy given post Dobbs vs. Jackson Women's**
29 **Health Organization restrictions.**
30

31 **RECOMMENDATION C:**

32
33 **Resolution 227 be adopted as amended.**
34

35 **RECOMMENDATION D:**

36
37 **The title of Resolution 227 be changed to read as**
38 **follows:**
39

40 **ACCESS TO METHOTREXATE AND OTHER**
41 **MEDICATIONS BASED ON CLINICAL DECISIONS**
42

43 **HOD ACTION: Resolution 227 adopted as amended with a**
44 **change of title.**
45

46 **ACCESS TO METHOTREXATE AND OTHER MEDICATIONS**
47 **BASED ON CLINICAL DECISIONS**
48

49 **RESOLVED, That our American Medical Association work to create a formal process to**
50 **review pharmaceutical practices related to refusal of methotrexate and other drugs on**

1 the basis that it could be used off-label for pregnancy termination (Directive to Take
2 Action); and be it further

3
4 RESOLVED, That our AMA work to provide educational guidance on state-specific laws
5 that have impacted the distribution of methotrexate given post Dobbs vs. Jackson
6 Women's Health Organization restrictions. (Directive to Take Action)

7
8 Your Reference Committee heard testimony in support of the spirit of Resolution 227.
9 Testimony stated that patients, particularly those living where abortion is now illegal and,
10 in those states where abortion laws are unclear or changing, are facing access
11 challenges to methotrexate. Testimony was also heard that some pharmacies and
12 pharmacists are refusing to stock or dispense the drug. Testimony noted that
13 methotrexate is a first-line treatment for several prevalent conditions and disruptions in
14 care risk worsening health conditions, suffering, and death for patients that cannot safely
15 access methotrexate. Testimony was not supportive of the development of a formal
16 process for reviewing pharmaceuticals and instead several amendments were offered
17 that would direct our AMA to monitor and oppose restrictions on pharmaceutical
18 practices that limit access to medications such as methotrexate. Your Reference
19 Committee heard considerable testimony in support of broadening the language to
20 include all medications that could potentially terminate a pregnancy but are prescribed
21 for other clinical reasons. Therefore, your Reference Committee recommends that
22 Resolution 227 be adopted as amended.
23

- 1 (16) RESOLUTION 228 - REQUIREMENTS FOR PHYSICIAN
2 SELF -REPORTING OF OUTPATIENT MENTAL HEALTH
3 SERVICES, TREATMENTS OR MEDICATIONS TO
4 CREDENTIALING AGENCIES AND INSURERS
5

6 **RECOMMENDATION A:**

7
8 **The first Resolve of Resolution 228 be deleted.**

9
10 ~~**RESOLVED, That our American Medical Association**~~
11 ~~**compile a report summarizing which states have**~~
12 ~~**implemented the suggestions that medical boards**~~
13 ~~**should not require disclosure of mental health**~~
14 ~~**conditions as a condition for re-licensure, as listed in**~~
15 ~~**Policy H-275.945, "Self-Incriminating Questions on**~~
16 ~~**Applications for Licensure and Specialty Boards"**~~
17 ~~**(Directive to Take Action); and be if further**~~

18
19 **RECOMMENDATION B:**

20
21 **The second Resolve of Resolution 228 be deleted.**

22
23 ~~**RESOLVED, That our AMA advocate to applicable**~~
24 ~~**organizations, such as Federation of State Medical**~~
25 ~~**Boards and Joint Commission, that state licensure**~~
26 ~~**boards, hospital credentialing committees, private and**~~
27 ~~**public health insurers and medical specialty boards**~~
28 ~~**refrain from asking whether physicians are currently**~~
29 ~~**receiving outpatient mental health care while**~~
30 ~~**continuing to ask whether they are currently impaired,**~~
31 ~~**as stated in AMA Policy H-295.858 (2), "Access to**~~
32 ~~**Confidential Health Services for Medical Students and**~~
33 ~~**Physicians"**~~ (Directive to Take Action); and be it
34 further
35
36

RECOMMENDATION C:

The third Resolve of Resolution 228 be amended by deletion to read as follows:

~~RESOLVED, That our AMA advocate to applicable organizations, such as Federation of State Medical Boards and Joint Commission, that Substance Use Disorder (SUD) conditions currently managed with the assistance of a state's Physicians' Health Program (PHP) (or similar entity) need not be reported on applications for re-credentialing by state licensure boards, hospital credentialing committees, private and public health insurers and medical specialty boards, because participation in a PHP ensures strict accountability on the part of physicians with a history of SUD, with this accountability enabling these physicians to such successfully and safely re-engage in the practice of medicine. (New HOD Policy)~~

RECOMMENDATION D:

Resolution 228 be adopted as amended.

RECOMMENDATION E:

That AMA Policy H-295.858 be reaffirmed.

HOD ACTION: Resolution 228 adopted as amended and AMA Policy H-295.858 reaffirmed.

RESOLVED, That our American Medical Association compile a report summarizing which states have implemented the suggestions that medical boards should not require disclosure of mental health conditions as a condition for re-licensure, as listed in Policy H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards" (Directive to Take Action); and be if further

RESOLVED, That our AMA advocate to applicable organizations, such as Federation of State Medical Boards and Joint Commission, that state licensure boards, hospital credentialing committees, private and public health insurers and medical specialty boards refrain from asking whether physicians are currently receiving outpatient mental health care while continuing to ask whether they are currently impaired, as stated in AMA Policy H-295.858 (2), "Access to Confidential Health Services for Medical Students and Physicians" (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to applicable organizations, such as Federation of State Medical Boards and Joint Commission, that Substance Use Disorder (SUD) conditions currently managed with the assistance of a state's Physicians' Health Program (PHP) (or similar entity) need not be reported on applications for re-credentialing by state licensure boards, hospital credentialing committees, private and

1 public health insurers and medical specialty boards, because participation in a PHP
2 ensures strict accountability on the part of physicians with a history of SUD, with this
3 accountability enabling these physicians to such successfully and safely re-engage in
4 the practice of medicine. (New HOD Policy)
5

6 Your Reference Committee heard compelling testimony in support of Resolution 228.
7 Your Reference Committee agrees with the importance of removing inappropriate,
8 stigmatizing questions about mental health and substance use disorders from medical
9 licensing applications, credentialing applications, medical liability applications, and
10 applications and other forms that medical trainees must complete for medical school,
11 residency, and fellowship programs. Testimony also highlighted that our AMA is already
12 working with myriad groups ranging from state medical boards to health systems, to
13 liability insurance carriers, to implement AMA policy. Your Reference Committee
14 appreciates the call for a report on our AMA activities, but also notes that our AMA
15 regularly communicates on its wellness efforts, including efforts to advance the
16 legislative and regulatory components of our AMA's physician health and wellness
17 campaign as part of the [AMA Recovery Plan](#). Your Reference Committee points to
18 recent AMA support for state-level victories, such as a new Delaware law that makes
19 clear that "a mental or physical disability or serious health condition does not prevent a
20 physician's ability to practice medicine with reasonable skill and safety when the
21 condition is reduced or ameliorated because of ongoing treatment," and that our AMA
22 supported [similar legislation](#) in Arizona earlier this year. Testimony noted that Virginia
23 enacted the country's first law in this area, and AMA resources and medical society
24 advocacy also helped enact laws in South Dakota and Indiana. Other AMA advocacy
25 highlights include AMA's partnership with the Federation of State Medical Boards
26 (FSMB) and the Dr. Lorna Breen Heroes' Foundation to seek revision of inappropriate
27 and stigmatizing questions on medical licensing applications; AMA ongoing analysis of
28 state medical licensing applications and reflected [online](#); AMA work with state medical
29 societies and medical boards to obtain every licensing application for analysis and
30 potential advocacy if the questions are not aligned with AMA policy; AMA advocacy and
31 partnership with [Henry Ford Health](#) to revise its credentialing application; and AMA
32 partnership with the Federation of State Physician Health Programs (FSPHP) to take
33 action in support of physicians seeking confidential care for health, wellness, and
34 impairment. Your Reference Committee agrees that physicians receiving care from a
35 PHP should not be stigmatized vis-à-vis disclosure on a medical licensing, credentialing
36 or other application given PHPs' success in effectively treating and safely returning
37 physicians to work. Your Reference Committee encourages the House to review an
38 [AMA issue brief](#) that outlines many of these advocacy issues and best practices for
39 legislative and regulatory advocacy. Your Reference Committee received an amendment
40 that would streamline the asks within the Resolution and align with current AMA policy to
41 decrease redundancy. Your Reference Committee, therefore, recommends that
42 Resolution 228 be adopted as amended in lieu of Resolution 228 and that existing AMA
43 policies D-405.972, H-275.972, H-295.858, and H-95.913 be reaffirmed.
44

45 **Access to Confidential Health Services for Medical Students and** 46 **Physicians H-295.858** 47

48 1. Our AMA will ask the Liaison Committee on Medical Education, Commission
49 on Osteopathic College Accreditation, American Osteopathic Association, and

- 1 Accreditation Council for Graduate Medical Education to encourage medical
2 schools and residency/fellowship programs, respectively, to:
- 3 A. Provide or facilitate the immediate availability of urgent and emergent access
4 to low-cost, confidential health care, including mental health and substance use
5 disorder counseling services, that: (1) include appropriate follow-up; (2) are
6 outside the trainees' grading and evaluation pathways; and (3) are available
7 (based on patient preference and need for assurance of confidentiality) in
8 reasonable proximity to the education/training site, at an external site, or through
9 telemedicine or other virtual, online means;
- 10 B. Ensure that residency/fellowship programs are abiding by all duty hour
11 restrictions, as these regulations exist in part to ensure the mental and physical
12 health of trainees;
- 13 C. Encourage and promote routine health screening among medical students
14 and resident/fellow physicians, and consider designating some segment of
15 already-allocated personal time off (if necessary, during scheduled work hours)
16 specifically for routine health screening and preventive services, including
17 physical, mental, and dental care; and
- 18 D. Remind trainees and practicing physicians to avail themselves of any needed
19 resources, both within and external to their institution, to provide for their mental
20 and physical health and well-being, as a component of their professional
21 obligation to ensure their own fitness for duty and the need to prioritize patient
22 safety and quality of care by ensuring appropriate self-care, not working when
23 sick, and following generally accepted guidelines for a healthy lifestyle.
- 24 2. Our AMA will urge state medical boards to refrain from asking applicants about
25 past history of mental health or substance use disorder diagnosis or treatment,
26 and only focus on current impairment by mental illness or addiction, and to
27 accept "safe haven" non-reporting for physicians seeking licensure or relicensure
28 who are undergoing treatment for mental health or addiction issues, to help
29 ensure confidentiality of such treatment for the individual physician while
30 providing assurance of patient safety.
- 31 3. Our AMA encourages medical schools to create mental health and substance
32 abuse awareness and suicide prevention screening programs that would:
- 33 A. be available to all medical students on an opt-out basis;
- 34 B. ensure anonymity, confidentiality, and protection from administrative action;
- 35 C. provide proactive intervention for identified at-risk students by mental health
36 and addiction professionals; and
- 37 D. inform students and faculty about personal mental health, substance use and
38 addiction, and other risk factors that may contribute to suicidal ideation.
- 39 4. Our AMA: (a) encourages state medical boards to consider physical and
40 mental conditions similarly; (b) encourages state medical boards to recognize
41 that the presence of a mental health condition does not necessarily equate with
42 an impaired ability to practice medicine; and (c) encourages state medical
43 societies to advocate that state medical boards not sanction physicians based
44 solely on the presence of a psychiatric disease, irrespective of treatment or
45 behavior.
- 46 5. Our AMA: (a) encourages study of medical student mental health, including
47 but not limited to rates and risk factors of depression and suicide; (b) encourages
48 medical schools to confidentially gather and release information regarding
49 reporting rates of depression/suicide on an opt-out basis from its students; and
50 (c) will work with other interested parties to encourage research into identifying

1 and addressing modifiable risk factors for burnout, depression and suicide across
2 the continuum of medical education.

3 6. Our AMA encourages the development of alternative methods for dealing with
4 the problems of student-physician mental health among medical schools, such
5 as: (a) introduction to the concepts of physician impairment at orientation; (b)
6 ongoing support groups, consisting of students and house staff in various stages
7 of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of
8 physical and mental well-being by heads of departments, as well as other faculty
9 members; and/or (f) the opportunity for interested students and house staff to
10 work with students who are having difficulty. Our AMA supports making these
11 alternatives available to students at the earliest possible point in their medical
12 education.

13 7. Our AMA will engage with the appropriate organizations to facilitate the
14 development of educational resources and training related to suicide risk of
15 patients, medical students, residents/fellows, practicing physicians, and other
16 health care professionals, using an evidence-based multidisciplinary approach.

- 17
18 (17) RESOLUTION 233 (LATE RESOLUTION 1001) -
19 URGENT AMA ASSISTANCE TO PUERTO RICO AND
20 FLORIDA AND A LONG-RANGE PROJECT FOR
21 PUERTO RICO
22

23 **RECOMMENDATION A:**

24
25 **The first Resolve of Resolution 233 be amended by**
26 **addition and deletion to read as follows:**

27
28 **RESOLVED, That our American Medical Association,**
29 **~~particularly the Department of Advocacy, move~~**
30 **~~urgently, meeting with the Biden Administration to~~**
31 **~~work with the Agencies, in particular the US Health~~**
32 **~~and Human Services Administration and its Center for~~**
33 **~~Medicare and Medicaid Services, the US Department of~~**
34 **~~Defense and the US Department of Homeland Security~~**
35 **~~and its Federal Emergency Management Agency~~**
36 **promptly urge all relevant government agencies and**
37 **Congress to provide all available federal disaster**
38 **assistance to the Territory of Puerto Rico and the State**
39 **of Florida including emergent, short term adjustments,**
40 **in Federal based health reimbursements to physicians,**
41 **hospitals, clinics, and Rural Health Care systems**
42 **(Directive to Take Action); and be it further**
43

1 **RECOMMENDATION B:**

2
3 The second Resolve of Resolution 233 be deleted.

4
5 ~~RESOLVED, That our AMA work with all pertinent~~
6 ~~stakeholders in Puerto Rico to develop LONG TERM~~
7 ~~strategies to solve LONG TERM health care financing~~
8 ~~in the Territory. (Directive to Take Action)~~

9
10 **RECOMMENDATION C:**

11
12 Resolution 233 be amended by addition of a new
13 resolve to read as follows:

14
15 RESOLVED, That AMA Policy H-390.953 (Medicare
16 Payments for Physicians' Services in Puerto Rico),
17 which calls on our AMA to support the elimination of
18 inequities in Medicare reimbursement so that
19 physicians' fees for Medicare patients in Puerto Rico
20 are adjusted according to the Medicare regulations
21 applicable in the continental United States, be
22 reaffirmed.

23
24 **RECOMMENDATION D:**

25
26 Resolution 233 be adopted as amended.

27
28 **RECOMMENDATION E:**

29
30 AMA Policy D-290.975 be amended by addition and
31 deletion to read as follows:

- 32
33 1. Our AMA will urge and advocate the U.S. Congress
34 to quickly pass legislation to provide adequately,
35 stable, long-term funding for Puerto Rico's,
36 the U.S. Virgin Islands', and other U.S. territories'
37 Medicaid Programs.
38 2. Our AMA will urge and advocate for the Centers for
39 Medicare and Medicaid Services to implement
40 temporary emergency regulatory Medicare and
41 Medicaid funding waivers to help restore access to
42 health care services in Puerto Rico and the U.S.
43 Virgin Islands.

44
45 **RECOMMENDATION F:**

46

1 **AMA Policy D-290.975 be adopted as amended.**

2

3 **HOD ACTION: Resolution 233 adopted as amended and**
4 **AMA Policy D-290.975 adopted as amended.**

5

6 RESOLVED, That our American Medical Association, particularly the Department of
7 Advocacy, move urgently, meeting with the Biden Administration to work with the
8 Agencies, in particular the US Health and Human Services Administration and its Center
9 for Medicare and Medicaid Services, the US Department of Defense and the US
10 Department of Homeland Security and its Federal Emergency Management Agency to
11 provide all available assistance to the Territory of Puerto Rico and the State of Florida
12 including emergent, short term adjustments, in Federal based health reimbursements to
13 physicians, hospitals, clinics, and Rural Health Care systems (Directive to Take Action);
14 and be it further

15

16 RESOLVED, That our AMA work with all pertinent stakeholders in Puerto Rico to
17 develop LONG TERM strategies to solve LONG TERM health care financing in the
18 Territory. (Directive to Take Action).

19

20 Your Reference Committee heard mostly positive testimony in favor of adopting
21 Resolution 233. Your Reference Committee heard that both Puerto Rico and Florida
22 were devastated by recent hurricanes Fiona and Ian, including suffering damage to
23 health care infrastructure and services with total damage estimated in the billions of
24 dollars. Testimony further highlighted that Puerto Rico has been severely impacted over
25 the past five years by a series of disasters, including Hurricanes Irma and Maria in 2017,
26 the 2019-2020 earthquakes, the COVID-19 public health emergency, and most recently
27 Hurricane Fiona. Testimony stated that funding inequities have plagued Puerto Rico's
28 health care system, including struggles with lower Medicaid caps and Federal Medical
29 Assistance Percentages (FMAP), than most of the U.S. and that Puerto Rico needs both
30 short-term funding and long-term solutions to help improve its health care infrastructure
31 and Medicaid and Medicare financing. Your Reference Committee also heard that our
32 AMA supports the underlying goal of providing sustained Medicare and Medicaid funding
33 assistance to Puerto Rico other U.S. territories, and Southeastern states following a
34 series of serious hurricanes. Testimony stated that, as drafted, the resolution conflates
35 general financial disaster assistance from the federal government with the need for
36 Congress to provide long-term Medicaid and Medicare funding solutions for the U.S.
37 territories. In addition, your Reference Committee heard that Congress is expected to
38 pass legislation in the upcoming lame duck session that separately addresses both long-
39 term Medicaid payment stability in the U.S. territories and hurricane disaster relief. An
40 amendment was offered to clarify that our AMA advocate in support of general disaster
41 funding for Puerto Rico and the State of Florida to assist with the rebuilding effort
42 following Hurricanes Fiona and Ian, and to modify existing AMA Policy D-290.975—
43 related to Medicaid Funding and Assistance to Puerto Rico—to urge Congress to quickly
44 pass legislation to provide adequate, stable, long-term funding the Puerto Rico and other
45 U.S. territories' Medicaid programs. Your Reference Committee agrees with this
46 amendment and, therefore, recommends that Resolution 233 be adopted as amended.

47

48

49

50

1 **Medicare Payments for Physicians' Services in Puerto Rico H-390.953**

2
3 The AMA supports the elimination of inequities in Medicare reimbursement so
4 that physicians' fees for Medicare patients in Puerto Rico are adjusted according
5 to the Medicare regulations applicable in the continental United States.
6

1 **RECOMMENDED FOR REFERRAL**

2
3 (18) RESOLUTION 214 – UNIVERSAL GOOD SAMARITAN
4 STATUTE

5
6 **RECOMMENDATION:**

7
8 **Resolution 214 be referred.**

9
10 **HOD ACTION: Resolution 214 referred.**

11
12 RESOLVED, That our American Medical Association help protect patients in need of
13 emergency care and protect physicians and other responders by advocating for a
14 national “universal” Good Samaritan Statute (Directive to Take Action); and be it further

15
16 RESOLVED, That our AMA advocate for the unification of the disparate statutes by
17 creation of a national standard via either federal legislation or through policy directed by
18 the Department of Health and Human Services [HHS] to specify terms that would protect
19 rescuers from legal repercussion as long as the act by the rescuer meets the specified
20 universal minimal standard of conduct and the good faith requirement, regardless of the
21 event location; thus, effectively eliminating variations in the state statutes to facilitate the
22 intent of the Good Samaritan statutes removing barriers that could impede the prompt
23 rendering of emergency care. (Directive to Take Action)

24
25 Your Reference Committee heard mixed testimony concerning Resolution 214.
26 Testimony noted that more needs to be done to support strong protections of physicians
27 responding as Good Samaritans, regardless of location within the United States and
28 regardless of the type of medical emergency they are called upon to address. Testimony
29 highlighted that our AMA already has policy that promotes shielding physician Good
30 Samaritans from liability while rendering treatment responsive to the Covid-19 public
31 health emergency, the opioid overdose epidemic, and in-flight medical emergencies.
32 However, testimony also stated that our AMA should not create policy that would
33 preempt existing state law that is more protective than that of a national minimum
34 standard. Your Reference Committee agrees with the goal of Resolution 214 but
35 recognizes that there are numerous legal nuances that need to be more thoroughly
36 considered before crafting policy that would create a national Good Samaritan
37 protection. Therefore, your Reference Committee, due to the complexity of the interplay
38 between state laws and federal law, recommends that Resolution 214 be referred.

39
40 (19) RESOLUTION 232 - OBTAINING PROFESSIONAL
41 RECOGNITION FOR MEDICAL SERVICE
42 PROFESSIONALS

43
44 **RECOMMENDATION:**

45
46 **Resolution 232 be referred.**

47
48 **HOD ACTION: Resolution 232 referred.**

49

1 RESOLVED, That our American Medical Association collaborate with leadership of the
2 National Association of Medical Staff Services' Advocacy and Government Relations
3 teams to advocate to the U.S. Department of Labor Statistics for obtaining a unique
4 standard occupational classification code during the next revision for medical service
5 professionals to maintain robust medical credentialing for patient safety (Directive to
6 Take Action).

7
8 Your Reference Committee heard testimony generally supporting Resolution 232 and
9 recognizing the support that medical service professionals (MSPs) give to medical staff
10 by performing core functions such as credentialing. It was noted that the work that MSPs
11 do helps make the credentialing process more efficient and less administratively
12 burdensome on physicians. Your Reference Committee heard that MSPs have
13 previously been denied a standard occupation classification by the Department of Labor
14 Statistics but are unsure of the reason for this denial. Moreover, testimony expressed
15 concerns that the Resolution raised several questions that required further information
16 and consideration before determining what, if any, advocacy strategy might be most
17 effective in order to support MSPs and to achieve the goals of Resolution 232.
18 Therefore, your Reference Committee recommends that Resolution 232 be referred.

19
20

1 **RECOMMENDED FOR ADOPTION IN LIEU OF**

2
3 (20) **RESOLUTION 208 – COMPARING STUDENT DEBT,**
4 **EARNINGS, WORK HOURS, AND CAREER**
5 **SATISFACTION METRICS IN PHYSICIANS V. OTHER**
6 **HEALTH PROFESSIONALS**

7
8 **RECOMMENDATION A:**

9
10 **Alternate Resolution 208 be adopted in lieu of**
11 **Resolution 208.**

12
13 **FACTORS CAUSING BURNOUT**

14
15 **RESOLVED, That our AMA recognize that medical**
16 **students, resident physicians, and fellows face unique**
17 **challenges that contribute to burnout during medical**
18 **school and residency training, such as debt burden,**
19 **inequitable compensation, discrimination, limited**
20 **organizational or institutional support, stress,**
21 **depression, suicide, childcare needs, mistreatment,**
22 **long work and study hours, among others, and that**
23 **such factors be included as metrics when measuring**
24 **physician well-being, particularly for this population of**
25 **physicians. (New HOD Policy).**

26
27 **HOD ACTION: Alternate Resolution 208 adopted in lieu of**
28 **Resolution 208.**

29
30 **RESOLVED, That our American Medical Association's advocacy efforts be informed by**
31 **the fact that student debt burden is higher for physicians when compared to physician**
32 **assistants and nurse practitioners (Directive to Take Action); and be it further**

33
34 **RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total**
35 **career earnings of physicians compare to those physician assistants and nurse**
36 **practitioners in order to specifically discern if there is a financial disincentive to becoming**
37 **a physician, considering the relatively high student debt burden and work hours of**
38 **physicians; (b) if resident physicians provide a net financial benefit for hospitals and**
39 **healthcare institutions; (c) best practices for increasing resident physician compensation**
40 **so that their services may be more equitably reflected in their earnings; and (d) burnout**
41 **metrics using a standardized system to compare differences among physicians,**
42 **physician assistants and nurse practitioners (Directive to Take Action); and be it further**

43
44 **RESOLVED, That our AMA recognize that burnout-centered metrics do not fully**
45 **characterize work-life balance, particularly for individuals with varying socioeconomic,**
46 **racial and/or sexual minoritized backgrounds (New HOD Policy); and be it further**

47
48 **RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical**
49 **journal. (Directive to Take Action)**

50

1 Your Reference Committee heard limited testimony regarding Resolution 208. Your
2 Reference Committee heard that it would not be possible to conduct the study as
3 described in Resolution 208, as the data necessary to conduct a study as framed are not
4 available and that even if the data were available they would not be collected
5 comparably across professions. In addition, testimony noted that compensation is
6 multifactorial and cannot be viewed in a vacuum as described in the original resolution.
7 Your Reference Committee was offered an alternate resolution that recognizes the
8 unique challenges facing medical students, resident physicians, and fellows that
9 contribute to burnout during medical school and residency training. Testimony on the
10 proposed alternate resolution also noted that the proposed alternate resolution would
11 ensure that metrics and future studies include factors unique to medical students,
12 resident physicians, and fellows, such as debt burden, inequitable compensation,
13 discrimination, limited organizational or institutional support, stress, depression, suicide,
14 childcare needs, long work and study hours, and mistreatment among other factors. The
15 authors of original Resolution 208 supported the alternate resolution. Therefore, your
16 Reference Committee recommends that Alternate Resolution 208 be adopted in lieu of
17 Resolution 208.

18

19 (21) RESOLUTION 229 - COVERAGE AND
20 REIMBURSEMENT FOR ABORTION SERVICES
21 RESOLUTION 231 – EXPANDING SUPPORT FOR
22 ACCESS TO ABORTION CARE
23

24

RECOMMENDATION:

25

26 **Alternate Resolution 229 be adopted in lieu of**
27 **Resolutions 229 and 231.**

28

29 **EXPANDING SUPPORT FOR ACCESS TO ABORTION**
30 **CARE**

31

32 **RESOLVED, That our AMA advocate for broad and**
33 **equitable access to abortion services, public and**
34 **private coverage of abortion services, and funding of**
35 **abortion services in public programs.**

36

1 **RESOLVED, That our AMA advocate for explicit**
2 **codification of legal protections to ensure broad,**
3 **equitable access to abortion services.**

4
5 **RESOLVED, That our AMA advocate for equitable**
6 **participation by physicians who provide abortion care**
7 **in insurance plans and public programs.**

8
9 **RESOLVED, That our AMA oppose the use of false or**
10 **inaccurate terminology and disinformation in**
11 **policymaking to impose restrictions and bans on**
12 **evidence-based health care, including reproductive**
13 **health care.**

14
15 **HOD ACTION: Alternate Resolution 229 adopted in lieu of**
16 **Resolutions 229 and 231.**

17
18 **Resolution 229 – Coverage and Reimbursement For Abortion Services**

19 RESOLVED, That our AMA advocate for legislation and regulation to (1) lift all
20 restrictions on public funding for abortion services and (2) guarantee coverage of
21 evidence-based abortion services by all plans and programs that are publicly funded or
22 subsidized; and be it further

23
24 RESOLVED, That our AMA advocate for policies that guarantee evidence-based
25 abortion services are covered without barriers by private health plans, including
26 designating abortion services as an essential health benefit; and be it further

27
28 RESOLVED, That our AMA work with state medical societies to advocate for policies
29 requiring abortion coverage in state private, public, and subsidized plans; and be it
30 further

31
32 RESOLVED, That our AMA oppose restrictions on physicians and other health
33 professionals who provide abortion care from participating in or being reimbursed by
34 federal and state funded or subsidized health coverage.

35
36 **Resolution 231 – Expanding Support for Access to Abortion Care**

37 RESOLVED, That our AMA recognize that policies and legislation that limit access to
38 abortion care are serious threats to public health; and be it further

39
40 RESOLVED, That our AMA will advocate for the explicit codification of protections for
41 abortion care consistent with AMA policy into federal law; and be it further

42
43 RESOLVED, That our AMA oppose efforts to exclude provisions from spending bills
44 which limit federal funds from being used for abortion care; and be it further

45
46 RESOLVED, That our AMA collaborate with relevant stakeholders including state
47 medical societies to encourage amendments to existing state laws so that a “fetal
48 heartbeat” is not inaccurately stated as synonymous with the first evidence of embryonic
49 cardiac activity.

50

1 Your Reference Committee heard testimony on Resolutions 229 and 231. Testimony
2 highlighted the importance of equitable access to abortion services, public and private
3 coverage of abortion services, funding of abortion services in public programs, and the
4 codification of protections to ensure broad, equitable access to abortion services.
5 However, your Reference Committee heard that the resolve clauses for Resolutions 229
6 and 231 were redundant and needed to be streamlined in order to make cohesive policy.
7 It was stated that adopting a version of Resolutions 229 and 231 would be a powerful
8 statement by our AMA and would bolster AMA advocacy on all the issues related to
9 abortion services. Your Reference Committee was offered an alternate resolution that
10 conveys the spirit of both resolutions while concisely conveying the importance of the
11 legalization and funding abortion services across all venues. The alternate resolution
12 also opposed the use of false or inaccurate terminology and disinformation in
13 policymaking to impose restrictions and bans on evidence-based health care, including
14 reproductive health care and to advocate for equitable participation by physicians who
15 provide abortion care in insurance plans and public programs. This alternate resolution
16 received overwhelming support. Therefore, your Reference Committee recommends that
17 Alternate Resolution 229 be adopted in lieu of Resolution 229 and Resolution 231.
18
19
20

1 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

2
3 (22) **RESOLUTION 213 – HAZARD PAY DURING A**
4 **DISASTER EMERGENCY**

5
6 **RECOMMENDATION:**

7
8 **That AMA Policies D-130.970 and D-390.947 be**
9 **reaffirmed in lieu of Resolution 213.**

10
11 **HOD ACTION: AMA Policies D-130.970 and D-390.947**
12 **reaffirmed in lieu of Resolution 213.**

13
14 RESOLVED, That our American Medical Association work with the federation of
15 medicine to advocate for state or federal programs that would provide hazard pay
16 bonuses to physicians and other healthcare staff delivering care during a state or federal
17 disaster emergency. (Directive to Take Action)

18
19 Your Reference Committee heard limited testimony in favor of adopting Resolution 213
20 but also heard testimony in favor of reaffirmation of existing AMA policy in lieu of
21 adoption. Your Reference Committee heard that New York was “ground zero” in terms of
22 COVID-19, and its front-line physicians were greatly impacted. Testimony also
23 highlighted that New York State provided hazard pay to front-line physicians through the
24 state budget, and that this should be standard practice. Your Reference Committee also
25 heard strong testimony that the issue of hazard pay bonuses for frontline essential
26 workers, including physicians, was debated in Congress during the first year of the
27 COVID-19 pandemic, and while our AMA advocated for physician hazard pay bonuses,
28 they were included in legislation passed only by the House of Representatives. Your
29 Reference Committee further heard that hazard pay bonuses for physicians is
30 controversial in Congress, especially since Congress passed other financial packages
31 for physicians through millions of dollars in funding for grant programs and loan
32 programs to compensate them for losses incurred and extra expenses due to COVID-19.
33 Testimony also stated that, regarding future disaster emergencies, our AMA has existing
34 policies that provide direction for our AMA to advocate for additional funding for
35 physicians, and that these policies should be reaffirmed. Therefore, your Reference
36 Committee recommends that existing AMA policies D-390.947 and D-130.970 be
37 reaffirmed in lieu of Resolution 213.

38
39 **Development of Bridge Income Strategies for Physicians Impacted by**
40 **Officially Declared Disasters D-130.970**

41
42 Our AMA will evaluate strategies to create or support federal legislation and/or
43 regulations which would provide bridge financial support to physicians following
44 officially declared disasters to ensure an adequate supply of physicians to treat
45 the population of the recovering areas.

46
47 **Physician Payment Advocacy for Additional Work and Expenses Involved**
48 **in Treating Patients During the Covid-19 Pandemic and Future Public**
49 **Health Emergencies D-390.947**

50

1 Our AMA: (1) will work with interested national medical specialty societies and
2 state medical associations to advocate for regulatory action on the part of the
3 Centers for Medicare & Medicaid Services to implement a professional services
4 payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to
5 be drawn from additional funds appropriated for the public health emergency to
6 recognize the additional uncompensated costs associated with COVID-19
7 incurred by physicians during the COVID-19 Public Health Emergency; (2) will
8 work with interested national medical specialty societies and state medical
9 associations to continue to advocate that the Centers for Medicare & Medicaid
10 Services and private health plans compensate physicians for the additional work
11 and expenses involved in treating patients during a public health emergency, and
12 that any new payments be exempt from budget neutrality; and (3) encourages
13 interested parties to work in the CPT Editorial Panel and AMA/Specialty Society
14 RVS Update Committee (RUC) processes to continue to develop coding and
15 payment solutions for the additional work and expenses involved in treating
16 patients during a public health emergency.
17
18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee C

Ramin Manshadi, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

**2
3 RECOMMENDED FOR ADOPTION**

- 4
- 5 1. Council on Medical Education Report 1 – The Impact of Private Equity on
 - 6 Medical Training
 - 7
 - 8 2. Resolution 304 – Protecting State Medical Licensing Boards from External
 - 9 Political Influence

**10
11 RECOMMENDED FOR ADOPTION AS AMENDED**

- 12
- 13 3. Council on Medical Education Report 2 – Mitigating Demographic and
 - 14 Socioeconomic Inequities in the Residency and Fellowship Selection Process
 - 15
 - 16 4. Resolution 302 – Expanding Employee Leave to Include Miscarriage and
 - 17 Stillbirth
 - 18
 - 19 Resolution 303 – Medical Student Leave Policy
 - 20
 - 21 Resolution 308 – Paid Family/Medical Leave in Medicine
 - 22
 - 23 5. Resolution 305 – Encouraging Medical Schools to Sponsor Pipeline Programs to
 - 24 Medicine for Underrepresented Groups
 - 25
 - 26 6. Resolution 306 – Increased Credit for Continuing Medical Education Preparation
 - 27
 - 28 7. Resolution 309 – Bereavement Leave for Medical Students and Physicians
 - 29
 - 30 8. Resolution 310 – Enforce AMA Principles on Continuing Board Certification
 - 31
 - 32 9. Resolution 312 - Reporting of Residency Demographic Data
 - 33
 - 34 10. Resolution 313 – Request a two-year delay in ACCME Changes to State Medical
 - 35 Society Recognition Program
 - 36
 - 37 11. Resolution 316 – Recognizing Specialty Certifications for Physicians

1 12. Resolution 317 – Support for GME Training in Reproductive Services

2

3 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

4

5 13. Resolution 307 – Fair Compensation of Residents and Fellows

6

7 **RECOMMENDED FOR ADOPTION IN LIEU OF**

8

9 14. Resolution 311 – Supporting a Hybrid Residency and Fellowship Interview
10 Process

11

12 **Amendments: If you wish to propose an amendment to an item of business, click**
13 **here: [Submit New Amendment](#)**

14

15 Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation
16 Consent Calendar:

17

18 Resolution 314 – Balancing Supply and Demand for Physicians by 2030

19

Resolution 315 – Bedside Nursing and Health Care Staff Shortages

RECOMMENDED FOR ADOPTION

- 1
2
3 (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – THE
4 IMPACT OF PRIVATE EQUITY ON MEDICAL TRAINING

RECOMMENDATION:

7
8 **Recommendations in Council on Medical Education**
9 **Report 1 be adopted and the remainder of the report be**
10 **filed.**

11
12 **HOD ACTION: Recommendations in Council on Medical**
13 **Education Report 1 adopted and the remainder of the**
14 **report filed**

15
16 That our AMA:

- 17
18 1. Affirm that an institution or medical education training program academic mission should
19 not be compromised by a clinical training site's fiduciary responsibilities to an external
20 corporate or for-profit entity. (New HOD Policy)
21
22 2. Encourage GME training institutions, programs, and relevant stakeholders to: a.
23 demonstrate transparency on mergers and closures, especially as it relates to private
24 equity acquisition of GME programs and institutions, and demonstrate institutional
25 accountability to their trainees by making this information available to current and
26 prospective trainees;
27 b. uphold comprehensive policies which protect trainees, including those who are not
28 funded by Medicare dollars, to ensure the obligatory transfer of funds after institution
29 closure;
30 c. empower designated institutional officials (DIOs) to be involved in institutional decision-
31 making to advance such transparency and accountability in protection of their residents,
32 fellows, and physician faculty;
33 d. develop educational materials that can help trainees better understand the business of
34 medicine, especially at the practice, institution, and corporate levels;
35 e. develop policies highlighting the procedures and responsibilities of sponsoring
36 institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites
37 and make these policies available to current and prospective GME learners. (Directive to
38 Take Action)
39
40 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to
41 allow medical students and physicians to enroll in the program even if they receive some
42 or all of their training at a for-profit or governmental institution. (Directive to Take Action)
43
44 4. Support publicly funded independent research on the impact that private equity has on
45 graduate medical education. (New HOD Policy)
46

1 5. Encourage physician associations, boards, and societies to draft policy or release their
2 own issue statements on private equity to heighten awareness among the physician
3 community. (Directive to Take Action)

4
5 6. Encourage physicians who are contemplating corporate investor partnerships to
6 consider the ongoing education and welfare for trainee physicians who train under
7 physicians in that practice, including the financial implications of existing funding that is
8 used to support that training. (Directive to Take Action)

9
10 7. Amend Policy D-310.948 "Protection of Resident and Fellow Training in the Case of
11 Hospital or Training Program Closure" by addition to read as follows:
12 Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others
13 to monitor issues, collect data, and share information related to training programs run by
14 corporate and nonprofit entities and their effect on medical education. (Modify HOD Policy)

15
16 8. Reaffirm the following policies:

- 17
18 • H-310.904 "Graduate Medical Education and the Corporate Practice of Medicine"
19 • H-310.943 "Closing of Residency Programs"
20 • H-310.929 "Principles for Graduate Medical Education"
21 • H-215.981 "Corporate Practice of Medicine" (Reaffirm HOD policy)

22
23 9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind
24 HOD policy)

25
26 Your Reference Committee reviewed live and online testimony regarding this item.
27 Testimony was received suggesting a title change, in that the report encompasses entities
28 that are beyond private equity, to include United Healthcare, HCA, and Summa. Your
29 Reference Committee considered this point but felt that a title change would have been
30 beyond the intent and the scope of the report. Other testimony expressed strong support
31 for the report, noting how the influence of private equity is far from benign and may cause
32 significant disruptions to the education and training of future physicians as well as harm
33 to underserved communities that rely on safety net hospitals. Therefore, your Reference
34 Committee recommends that CME Report 1 be adopted.

1 (2) RESOLUTION 304 – PROTECTING STATE MEDICAL
2 LICENSING BOARDS FROM EXTERNAL POLITICAL
3 INFLUENCE
4

5 **RECOMMENDATION:**
6

7 **Resolution 304 be adopted.**
8

9 **HOD ACTION: Resolution 304 adopted**
10

11 RESOLVED, That our American Medical Association work with the Federation of State
12 Medical Boards and other interested parties to minimize external interference with the
13 independent functioning of state medical disciplinary and licensing boards. (Directive to
14 Take Action)

15
16 Your Reference Committee reviewed live and online testimony regarding this item.
17 Testimony for this item was largely supportive of the intent yet was mixed between
18 adoption and reaffirmation. Testimony in support of reaffirmation expressed that current
19 policy is broad and already encourages collaboration with other stakeholders. However,
20 there were concerns that current policy does not go far enough to adequately address the
21 present polarized political climate and interference by legislators to limit the ability of the
22 boards to enact their primary mission—that is, protection of the public. References were
23 made regarding current efforts to place licenses in jeopardy for meeting expected
24 standards of care. Therefore, your Reference Committee recommends that Resolution
25 304 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- 1
2
3 (3) COUNCIL ON MEDICAL EDUCATION REPORT 2 –
4 MITIGATING DEMOGRAPHIC AND SOCIOECONOMIC
5 INEQUITIES IN THE RESIDENCY AND FELLOWSHIP
6 SELECTION PROCESS
7

RECOMMENDATION A:

8
9
10 **Recommendation 5 in Council on Medical Education**
11 **Report 2 be amended by addition, to read as follows:**
12

13 **5. That our AMA advocate for and support innovation in**
14 **the undergraduate medical education to graduate**
15 **medical education transition, especially focusing on**
16 **the efforts of the Accelerating Change in Medical**
17 **Education initiative, to include pilot efforts to optimize**
18 **the residency/fellowship application and matching**
19 **process and study of the impact of using filters in the**
20 **Electronic Residency Application Service (ERAS) by**
21 **program directors on the diversity of entrants into**
22 **residency. (New HOD Policy)**
23

RECOMMENDATION B:

24
25
26 **Recommendation 6 in Council on Medical Education**
27 **Report 2 be amended by addition and deletion, to read**
28 **as follows:**
29

30 **6. That our AMA encourage caution among medical**
31 **schools and residency/fellowship programs when**
32 **utilizing ~~monitor use of~~ novel online assessments for**
33 **sampling personal characteristics for the purpose of**
34 **medical school admissions or residency/fellowship**
35 **selection and monitor use and validity of these tools**
36 **and consider their impact on equity and diversity of the**
37 **physician workforce. (New HOD Policy)**
38

RECOMMENDATION C:

39
40
41 **Recommendations in Council on Medical Education**
42 **Report 2 be adopted as amended and the remainder of**
43 **the report be filed.**
44

45 **HOD ACTION: Recommendations in Council on Medical**
46 **Education Report 2 adopted as amended and the remainder**
47 **of the report filed**

1 **Recommendation 5 of Council on Medical Education Report 2**
2 **be amended by addition, to read as follows:**

3
4 **5. That our AMA advocate for and support innovation in**
5 **the undergraduate medical education to graduate**
6 **medical education transition, especially focusing on**
7 **the efforts of the Accelerating Change in Medical**
8 **Education initiative, to include pilot efforts to optimize**
9 **the residency/fellowship application and matching**
10 **process and encourage the study of the impact of using**
11 **filters in the Electronic Residency Application Service**
12 **(ERAS) by program directors on the diversity of**
13 **entrants into residency. (New HOD Policy)**

14
15 1. That our AMA encourage medical schools, medical honor societies, and
16 residency/fellowship programs to work toward ethical, equitable, and transparent
17 recruiting processes, which are made available to all applicants. (New HOD Policy)

18
19 2. That AMA Policy D-200.985, “Strategies for Enhancing Diversity in the Physician
20 Workforce,” be amended by addition and deletion, to read as follows:

21
22 Our AMA will recommend that medical school admissions committees and
23 residency/fellowship programs use holistic assessments of ~~admission~~ applicants
24 that take into account the diversity of preparation and the variety of talents that
25 applicants bring to their education with the goal of improving health care for all
26 communities. (Modify Current HOD Policy)

27
28 3. That our AMA advocate for residency and fellowship programs to avoid using objective
29 criteria available in the Electronic Residency Application Service (ERAS) application
30 process as the sole determinant for deciding which applicants to offer interviews.
31 (Directive to Take Action)

32
33 4. That our AMA advocate to remove membership in medical honor societies as a
34 mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby
35 limiting its use as an automated screening mechanism—and encourage applicants to
36 share this information within other aspects of the ERAS application. (Directive to Take
37 Action)

38
39 5. That our AMA advocate for and support innovation in the undergraduate medical
40 education to graduate medical education transition, especially focusing on the efforts of
41 the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize
42 the residency/fellowship application and matching process. (New HOD Policy)

43
44 6. That our AMA monitor use of novel online assessments for sampling personal
45 characteristics for the purpose of medical school admissions or residency/fellowship
46 selection and consider their impact on equity and diversity of the physician workforce.
47 (New HOD Policy)

1 7. That AMA Policy D-295.963(5), "Continued Support for Diversity in Medical Education,"
2 be rescinded, as having been fulfilled through this report:
3

4 ~~Our AMA will: ... work with appropriate stakeholders to study reforms to mitigate~~
5 ~~demographic and socioeconomic inequities in the residency and fellowship selection~~
6 ~~process, including but not limited to the selection and reporting of honor society~~
7 ~~membership and the use of standardized tools to rank applicants, with report back to the~~
8 ~~House of Delegates. (Rescind HOD Policy)~~
9

10 Your Reference Committee reviewed online and live testimony regarding this item.
11 Testimony was largely supportive of the recommendations of this well-written and
12 researched report and expressed support for efforts to reaffirm the AMA's commitment to
13 equity. Testimony on Recommendation 4 called for nationwide standardization of the
14 selection process into these honor societies in all medical schools, with a reexamination
15 of the criteria for membership and creation of objectively fair metrics that deal with
16 demographic and socioeconomic inequities in the selection process. Testimony offered
17 the following amendments: opposition to use of online personality assessments,
18 elimination of ERAS filters that could adversely impact international medical graduates,
19 and study of the effect of ERAS filters on equitable admissions. Your Reference
20 Committee believes these amendments go beyond the scope of this report and support
21 future studies to support equitable processes for GME applications. Therefore, your
22 Reference Committee recommends that CME Report 2 be adopted as amended.
23

24 (4) RESOLUTION 302 – EXPANDING EMPLOYEE LEAVE
25 TO INCLUDE MISCARRIAGE AND STILLBIRTH
26

27 RESOLUTION 303 – MEDICAL STUDENT LEAVE
28 POLICY
29

30 RESOLUTION 308 – PAID FAMILY/MEDICAL LEAVE IN
31 MEDICINE
32

33 **RECOMMENDATION A:**
34

35 **Policy H-405.960, "Policies for Parental, Family, and**
36 **Medical Necessity Leave," be amended by addition and**
37 **deletion, to read as follows:**
38

39 **H-405.960, Policies for Parental, Family, and Medical**
40 **Necessity Leave**
41

42 **AMA adopts as policy the following guidelines for, and**
43 **encourages the implementation of, Parental, Family and**
44 **Medical Necessity Leave for Medical Students and**
45 **Physicians:**

1 **1. Our AMA urges ~~medical schools~~, residency training**
2 **programs, medical specialty boards, the Accreditation**
3 **Council for Graduate Medical Education, and medical**
4 **group practices to incorporate and/or encourage**
5 **development of leave policies, including parental,**
6 **family, and medical leave policies, as part of the**
7 **physician's standard benefit agreement.**

8
9 **2. Recommended components of parental leave**
10 **policies for ~~medical students and~~ physicians include:**
11 **(a) duration of leave allowed before and after delivery;**
12 **(b) category of leave credited; (c) whether leave is paid**
13 **or unpaid; (d) whether provision is made for**
14 **continuation of insurance benefits during leave, and**
15 **who pays the premium; (e) whether sick leave and**
16 **vacation time may be accrued from year to year or used**
17 **in advance; (f) how much time must be made up in order**
18 **to be considered board eligible; (g) whether make-up**
19 **time will be paid; (h) whether schedule**
20 **accommodations are allowed; and (i) leave policy for**
21 **adoption.**

22
23 **3. AMA policy is expanded to include physicians in**
24 **practice, reading as follows: (a) residency program**
25 **directors and group practice administrators should**
26 **review federal law concerning maternity leave for**
27 **guidance in developing policies to assure that pregnant**
28 **physicians are allowed the same sick leave or disability**
29 **benefits as those physicians who are ill or disabled; (b)**
30 **staffing levels and scheduling are encouraged to be**
31 **flexible enough to allow for coverage without creating**
32 **intolerable increases in other physicians' workloads,**
33 **particularly in residency programs; and (c) physicians**
34 **should be able to return to their practices or training**
35 **programs after taking parental leave without the loss of**
36 **status.**

37
38 **4. Our AMA will study the impact on and feasibility of**
39 **~~encourages~~ medical schools, residency programs,**
40 **specialty boards, and medical group practices ~~to~~**
41 **~~incorporate~~ incorporating into their parental leave**
42 **policies a ~~six~~¹²-week minimum leave allowance, with**
43 **the understanding that no parent ~~should~~ be required to**
44 **take a minimum leave.**

45
46 **5. Our AMA recommends that medical practices,**
47 **departments and training programs strive to provide 12**
48 **weeks of paid parental, family and medical necessity**

1 leave in a 12-month period for their attending and
2 trainee physicians as needed.

3
4 ~~5.~~ 6. Residency program directors should review federal
5 and state law for guidance in developing policies for
6 parental, family, and medical leave.

7
8 ~~6.~~ 7. Medical students and physicians who are unable to
9 work because of pregnancy, childbirth, abortion or
10 stillbirth, and other related medical conditions should
11 be entitled to such leave and other benefits on the same
12 basis as other physicians who are temporarily unable
13 to work for other medical reasons.

14
15 ~~7.~~ 8. Residency programs should develop written
16 policies on ~~parental leave, family leave, and medical~~
17 ~~leave~~ for physicians. Such written policies should
18 include the following elements: (a) leave policy for birth
19 or adoption; (b) duration of leave allowed before and
20 after delivery; (c) duration of leave allowed after
21 abortion or stillbirth; ~~(e)~~(d) category of leave credited
22 (e.g., sick, vacation, parental, unpaid leave, short term
23 disability); ~~(d)~~(e) whether leave is paid or unpaid; ~~(e)~~(f)
24 whether provision is made for continuation of
25 insurance benefits during leave and who pays for
26 premiums; ~~(f)~~(g) whether sick leave and vacation time
27 may be accrued from year to year or used in advance;
28 ~~(g)~~(h) extended leave for resident physicians with
29 extraordinary and long-term personal or family medical
30 tragedies for periods of up to one year, without loss of
31 previously accepted residency positions, for
32 devastating conditions such as terminal illness,
33 permanent disability, or complications of pregnancy
34 that threaten maternal or fetal life; ~~(h)~~(i) how time can
35 be made up in order for a resident physician to be
36 considered board eligible; ~~(i)~~(j) what period of leave
37 would result in a resident physician being required to
38 complete an extra or delayed year of training; ~~(j)~~(k)
39 whether time spent in making up a leave will be paid;
40 and ~~(k)~~(l) whether schedule accommodations are
41 allowed, such as reduced hours, no night call, modified
42 rotation schedules, and permanent part-time
43 scheduling.

44
45 ~~8.~~ 9. Medical schools should develop written policies on
46 parental leave, family leave, and medical leave for
47 medical students. Such written policies should include
48 the following elements: (a) leave policy for birth or

1 adoption; (b) duration of leave allowed before and after
2 delivery; (c) extended leave for medical students with
3 extraordinary and long-term personal or family medical
4 tragedies, without loss of previously accepted medical
5 school seats, for devastating conditions such as
6 terminal illness, permanent disability, or complications
7 of pregnancy that threaten maternal or fetal life; (d) how
8 time can be made up in order for a medical students to
9 be eligible for graduation with minimal or no delays; (e)
10 what period of leave would result in a medical student
11 being required to complete an extra or delayed year of
12 training; and (f) whether schedule accommodations are
13 allowed, such as modified rotation schedules, no night
14 duties, and flexibility with academic testing schedules.

15
16 **8. 10. Our AMA endorses the concept of equal parental**
17 **leave for birth and adoption as a benefit for resident**
18 **physicians, medical students, and physicians in**
19 **practice regardless of gender or gender identity.**

20
21 **9. 11. Staffing levels and scheduling are encouraged to**
22 **be flexible enough to allow for coverage without**
23 **creating intolerable increases in the workloads of other**
24 **physicians, particularly those in residency programs.**

25
26 **40. 12. Physicians should be able to return to their**
27 **practices or training programs after taking parental**
28 **leave, family leave, or medical leave without the loss of**
29 **status.**

30
31 **44. 13. Residency program directors must assist**
32 **residents in identifying their specific requirements (for**
33 **example, the number of months to be made up) because**
34 **of leave for eligibility for board certification and must**
35 **notify residents on leave if they are in danger of falling**
36 **below minimal requirements for board eligibility.**
37 **Program directors must give these residents a**
38 **complete list of requirements to be completed in order**
39 **to retain board eligibility.**

40
41 **42. 14. Our AMA encourages flexibility in residency**
42 **training programs and medical schools incorporating**
43 **parental leave and alternative schedules for pregnant**
44 **trainees house staff.**

45
46 **43. 15. In order to accommodate leave protected by the**
47 **federal Family and Medical Leave Act, our AMA**
48 **encourages all specialties within the American Board of**

1 **Medical Specialties to allow graduating residents to**
2 **extend training up to 12 weeks after the traditional**
3 **residency completion date while still maintaining board**
4 **eligibility in that year.**

5
6 **14. 16. These policies as above should be freely**
7 **available online and in writing to all current trainees and**
8 **applicants to medical school, residency or fellowship.**
9 **(Modify Current HOD Policy)**

10
11 **RECOMMENDATION B:**

12
13 **Policy H-420.979, “AMA Statement on Family and**
14 **Medical Leave,” be amended by addition, to read as**
15 **follows:**

16
17 **H-420.979, AMA Statement on Family and Medical**
18 **Leave**

19
20 **Our AMA supports policies that provide employees with**
21 **reasonable job security and continued availability of**
22 **health plan benefits in the event leave by an employee**
23 **becomes necessary due to documented medical**
24 **conditions. Such policies should provide for**
25 **reasonable periods of paid or unpaid:**

26
27 **(1) medical leave for the employee, including**
28 **pregnancy, abortion, and stillbirth;**

29
30 **(2) maternity leave for the employee-mother;**

31
32 **(3) leave if medically appropriate to care for a member**
33 **of the employee's immediate family, i.e., a spouse or**
34 **children; and**

35
36 **(4) leave for adoption or for foster care leading to**
37 **adoption. Such periods of leave may differ with respect**
38 **to each of the foregoing classifications, and may vary**
39 **with reasonable categories of employers. Such policies**
40 **should encourage voluntary programs by employers**
41 **and may provide for appropriate legislation (with or**
42 **without financial assistance from government). Any**
43 **legislative proposals will be reviewed through the**
44 **Association's normal legislative process for**
45 **appropriateness, taking into consideration all elements**
46 **therein, including classifications of employees and**
47 **employers, reasons for the leave, periods of leave**
48 **recognized (whether paid or unpaid), obligations on**

1 return from leave, and other factors involved in order to
2 achieve reasonable objectives recognizing the
3 legitimate needs of employees and employers. (Modify
4 Current HOD Policy)

5
6 **RECOMMENDATION C:**

7
8 **Amended Policy H-405.960 and H-420.979 be adopted in**
9 **lieu of Resolutions 302, 303, and 308.**

10
11 **HOD ACTION: Amended Policy H-405.960 and H-**
12 **420.979 adopted in lieu of Resolutions 302, 303, and**
13 **308.**

14
15 Res 302:

16
17 RESOLVED, That our American Medical Association amend Policy H-405.960, "Policies
18 for Parental, Family, and Medical Necessity Leave," by addition and deletion to read as
19 follows:

20
21 Policies for Parental, Family and Medical Necessity Leave H-405.960
22 AMA adopts as policy the following guidelines for, and encourages the implementation of,
23 Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

24
25 1. Our AMA urges medical schools, residency training programs, medical specialty
26 boards, the Accreditation Council for Graduate Medical Education, and medical group
27 practices to incorporate and/or encourage development of leave policies, including
28 parental, family, and medical leave policies, as part of the physician's standard benefit
29 agreement.

30
31 2. Recommended components of parental leave policies for medical students and
32 physicians include: (a) duration of leave allowed before and after delivery; (b) category of
33 leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
34 continuation of insurance benefits during leave, and who pays the premium; (e) whether
35 sick leave and vacation time may be accrued from year to year or used in advance; (f)
36 how much time must be made up in order to be considered board eligible; (g) whether
37 make-up time will be paid; (h) whether schedule accommodations are allowed; and (i)
38 leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.

39
40 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
41 residency program directors and group practice administrators should review federal law
42 concerning maternity leave for guidance in developing policies to assure that pregnant
43 physicians are allowed the same sick leave or disability benefits as those physicians who
44 are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough
45 to allow for coverage without creating intolerable increases in other physicians' workloads,
46 particularly in residency programs; and (c) physicians should be able to return to their
47 practices or training programs after taking parental leave without the loss of status.

48

1 4. Our AMA encourages medical schools, residency programs, specialty boards, and
2 medical group practices to incorporate into their parental leave policies a six-week
3 minimum leave allowance, with the understanding that no parent should be required to
4 take a minimum leave.

5
6 5. Residency program directors should review federal and state law for guidance in
7 developing policies for parental, family, and medical leave.

8
9 6. Medical students and physicians who are unable to work because of pregnancy,
10 childbirth, and other related medical conditions should be entitled to such leave and other
11 benefits on the same basis as other physicians who are temporarily unable to work for
12 other medical reasons.

13
14 7. Residency programs should develop written policies on parental leave, family leave,
15 and medical leave for physicians. Such written policies should include the following
16 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
17 after delivery; (c) duration of leave allowed after miscarriage or stillbirth; ~~(e)~~(d) category
18 of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e)
19 whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of
20 insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave and
21 vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended leave
22 for resident physicians with extraordinary and long-term personal or family medical
23 tragedies for periods of up to one year, without loss of previously accepted residency
24 positions, for devastating conditions such as terminal illness, permanent disability, or
25 complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be made
26 up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what period of
27 leave would result in a resident physician being required to complete an extra or delayed
28 year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l)
29 whether schedule accommodations are allowed, such as reduced hours, no night call,
30 modified rotation schedules, and permanent part-time scheduling.

31
32 8. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage,
33 and adoption as a benefit for resident physicians, medical students, and physicians in
34 practice regardless of gender or gender identity.

35
36 9. Staffing levels and scheduling are encouraged to be flexible enough to allow for
37 coverage without creating intolerable increases in the workloads of other physicians,
38 particularly those in residency programs.

39
40 10. Physicians should be able to return to their practices or training programs after taking
41 parental leave, family leave, or medical leave without the loss of status.

42
43 11. Residency program directors must assist residents in identifying their specific
44 requirements (for example, the number of months to be made up) because of leave for
45 eligibility for board certification and must notify residents on leave if they are in danger of
46 falling below minimal requirements for board eligibility. Program directors must give these
47 residents a complete list of requirements to be completed in order to retain board eligibility.

1 12. Our AMA encourages flexibility in residency training programs, incorporating parental
2 leave and alternative schedules for pregnant house staff.

3
4 13. In order to accommodate leave protected by the federal Family and Medical Leave
5 Act, our AMA encourages all specialties within the American Board of Medical Specialties
6 to allow graduating residents to extend training up to 12 weeks after the traditional
7 residency completion date while still maintaining board eligibility in that year.

8
9 14. These policies as above should be freely available online and in writing to all applicants
10 to medical school, residency or fellowship. (Modify Current HOD Policy); and be it further
11 RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for
12 physical and psychological healing afterwards, our AMA amend Policy H-420.979 "AMA
13 Statement on Family and Medical Leave," by addition to read as follows:

14 AMA Statement on Family and Medical Leave H-420.979

15 Our AMA supports policies that provide employees with reasonable job security and
16 continued availability of health plan benefits in the event leave by an employee becomes
17 necessary due to documented medical conditions. Such policies should provide for
18 reasonable periods of paid or unpaid:

19 (1) medical leave for the employee, including pregnancy; miscarriage, and stillbirth;

20 (2) maternity leave for the employee-mother;

21 (3) leave if medically appropriate to care for a member of the employee's immediate family,
22 i.e., a spouse or children; and

23 (4) leave for adoption or for foster care leading to adoption. Such periods of leave may
24 differ with respect to each of the foregoing classifications, and may vary with reasonable
25 categories of employers. Such policies should encourage voluntary programs by
26 employers and may provide for appropriate legislation (with or without financial assistance
27 from government). Any legislative proposals will be reviewed through the Association's
28 normal legislative process for appropriateness, taking into consideration all elements
29 therein, including classifications of employees and employers, reasons for the leave,
30 periods of leave recognized (whether paid or unpaid), obligations on return from leave,
31 and other factors involved in order to achieve reasonable objectives recognizing the
32 legitimate needs of employees and employers. (Modify Current HOD Policy)

33
34 Res 303:

35
36 RESOLVED, That our American Medical Association amend policy H-405.960 "Policies
37 for Parental, Family and Medical Necessity Leave" by addition and deletion to read as
38 follows:

39
40 Policies for Parental, Family and Medical Necessity Leave, H-405.960

41
42 AMA adopts as policy the following guidelines for, and encourages the implementation of,
43 Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

44
45 1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty
46 boards, the Accreditation Council for Graduate Medical Education, and medical group
47 practices to incorporate and/or encourage development of leave policies, including

1 parental, family, and medical leave policies, as part of the physician's standard benefit
2 agreement.

3
4 2. Recommended components of parental leave policies for ~~medical students and~~
5 physicians include: (a) duration of leave allowed before and after delivery; (b) category of
6 leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
7 continuation of insurance benefits during leave, and who pays the premium; (e) whether
8 sick leave and vacation time may be accrued from year to year or used in advance; (f)
9 how much time must be made up in order to be considered board eligible; (g) whether
10 make-up time will be paid; (h) whether schedule accommodations are allowed; and (i)
11 leave policy for adoption.

12 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
13 residency program directors and group practice administrators should review federal law
14 concerning maternity leave for guidance in developing policies to assure that pregnant
15 physicians are allowed the same sick leave or disability benefits as those physicians who
16 are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough
17 to allow for coverage without creating intolerable increases in other physicians' workloads,
18 particularly in residency programs; and (c) physicians should be able to return to their
19 practices or training programs after taking parental leave without the loss of status.

20
21 4. Our AMA encourages medical schools, residency programs, specialty boards, and
22 medical group practices to incorporate into their parental leave policies a six-week
23 minimum leave allowance, with the understanding that no parent should be required to
24 take a minimum leave.

25
26 5. Residency program directors should review federal and state law for guidance in
27 developing policies for parental, family, and medical leave.

28
29 6. Medical students and physicians who are unable to work because of pregnancy,
30 childbirth, and other related medical conditions should be entitled to such leave and other
31 benefits on the same basis as other physicians who are temporarily unable to work for
32 other medical reasons.

33
34 7. Residency programs should develop written policies on parental leave, family leave,
35 and medical leave for physicians. Such written policies should include the following
36 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
37 after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave,
38 short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made
39 for continuation of insurance benefits during leave and who pays for premiums; (f) whether
40 sick leave and vacation time may be accrued from year to year or used in advance; (g)
41 extended leave for resident physicians with extraordinary and long-term personal or family
42 medical tragedies for periods of up to one year, without loss of previously accepted
43 residency positions, for devastating conditions such as terminal illness, permanent
44 disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time
45 can be made up in order for a resident physician to be considered board eligible; (i) what
46 period of leave would result in a resident physician being required to complete an extra or
47 delayed year of training; (j) whether time spent in making up a leave will be paid; and (k)

1 whether schedule accommodations are allowed, such as reduced hours, no night call,
2 modified rotation schedules, and permanent part-time scheduling.

3
4 8. Medical schools should develop written policies on parental leave, family leave, and
5 medical leave for medical students. Such written policies should include the following
6 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
7 after delivery; (c) extended leave for medical students with extraordinary and long-term
8 personal or family medical tragedies, without loss of previously accepted medical school
9 seats, for devastating conditions such as terminal illness, permanent disability, or
10 complications of pregnancy that threaten maternal or fetal life; (d) how time can be made
11 up in order for a medical students to be eligible for graduation without delays; (e) what
12 period of leave would result in a medical student being required to complete an extra or
13 delayed year of training; and (f) whether schedule accommodations are allowed, such as
14 modified rotation schedules, no night duties, and flexibility with academic testing
15 schedules.

16
17 ~~8.~~ 9. Our AMA endorses the concept of equal parental leave for birth and adoption as a
18 benefit for resident physicians, medical students, and physicians in practice regardless of
19 gender or gender identity.

20
21 ~~9.~~ 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for
22 coverage without creating intolerable increases in the workloads of other physicians,
23 particularly those in residency programs.

24
25 ~~10.~~ 11. Physicians should be able to return to their practices or training programs after
26 taking parental leave, family leave, or medical leave without the loss of status.

27
28 ~~11.~~ 12. Residency program directors must assist residents in identifying their specific
29 requirements (for example, the number of months to be made up) because of leave for
30 eligibility for board certification and must notify residents on leave if they are in danger of
31 falling below minimal requirements for board eligibility. Program directors must give these
32 residents a complete list of requirements to be completed in order to retain board eligibility.

33
34 ~~12.~~ 13. Our AMA encourages flexibility in residency training programs and medical schools
35 incorporating parental leave and alternative schedules for pregnant trainees ~~house staff.~~

36
37 ~~13.~~ 14. In order to accommodate leave protected by the federal Family and Medical Leave
38 Act, our AMA encourages all specialties within the American Board of Medical Specialties
39 to allow graduating residents to extend training up to 12 weeks after the traditional
40 residency completion date while still maintaining board eligibility in that year.

41
42 ~~14.~~ 15. These policies as above should be freely available online and in writing to all
43 current trainees and applicants to medical school, residency or fellowship. (Modify Current
44 HOD Policy)

1 Res 308:

2
3 RESOLVED, That our American Medical Association policy H-405.960 "Policies for
4 Parental Family and Medical Necessity Leave" be amended by addition and deletion to
5 read as follows:

6
7 AMA adopts as policy the following guidelines for, and encourages the implementation of,
8 Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

9 1. Our AMA urges medical schools, residency training programs, medical specialty
10 boards, the Accreditation Council for Graduate Medical Education, and medical group
11 practices to incorporate and/or encourage development of leave policies, including
12 parental, family, and medical leave policies, as part of the physician's standard benefit
13 agreement.

14 2. Recommended components of parental leave policies for medical students and
15 physicians include: (a) duration of leave allowed before and after delivery; (b) category of
16 leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
17 continuation of insurance benefits during leave, and who pays the premium; (e) whether
18 sick leave and vacation time may be accrued from year to year or used in advance; (f)
19 how much time must be made up in order to be considered board eligible; (g) whether
20 make-up time will be paid; (h) whether schedule accommodations are allowed; and (i)
21 leave policy for adoption.

22 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
23 residency program directors and group practice administrators should review federal law
24 concerning maternity leave for guidance in developing policies to assure that pregnant
25 physicians are allowed the same sick leave or disability benefits as those physicians who
26 are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough
27 to allow for coverage without creating intolerable increases in other physicians' workloads,
28 particularly in residency programs; and (c) physicians should be able to return to their
29 practices or training programs after taking parental leave without the loss of status.

30 4. Our AMA encourages medical schools, residency programs, specialty boards, and
31 medical group practices to incorporate into their parental, family, and medical necessity
32 leave policies a six-twelve-week minimum leave allowance, with the understanding that
33 no parent individual should be required to take a minimum leave.

34 5. Our AMA recommends that medical practices, departments and training programs strive
35 to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month
36 period for their attending and trainee physicians as needed.

37 ~~56.~~ Residency program directors should review federal and state law for guidance in
38 developing policies for parental, family, and medical leave.

39 ~~67.~~ Medical students and physicians who are unable to work because of pregnancy,
40 childbirth, and other related medical conditions should be entitled to such leave and other
41 benefits on the same basis as other physicians who are temporarily unable to work for
42 other medical reasons.

43 ~~78.~~ Residency programs should develop written policies on parental leave, family leave,
44 and medical leave for physicians. Such written policies should include the following
45 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
46 after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave,
47 short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made
48 for continuation of insurance benefits during leave and who pays for premiums; (f) whether

1 sick leave and vacation time may be accrued from year to year or used in advance; (g)
2 extended leave for resident physicians with extraordinary and long-term personal or family
3 medical tragedies for periods of up to one year, without loss of previously accepted
4 residency positions, for devastating conditions such as terminal illness, permanent
5 disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time
6 can be made up in order for a resident physician to be considered board eligible; (i) what
7 period of leave would result in a resident physician being required to complete an extra or
8 delayed year of training; (j) whether time spent in making up a leave will be paid; and (k)
9 whether schedule accommodations are allowed, such as reduced hours, no night call,
10 modified rotation schedules, and permanent part-time scheduling.

11 ~~89.~~ Our AMA endorses the concept of equal parental leave for birth and adoption as a
12 benefit for resident physicians, medical students, and physicians in practice regardless of
13 gender or gender identity.

14 ~~910.~~ Staffing levels and scheduling are encouraged to be flexible enough to allow for
15 coverage without creating intolerable increases in the workloads of other physicians,
16 particularly those in residency programs.

17 ~~1011.~~ Physicians should be able to return to their practices or training programs after
18 taking parental leave, family leave, or medical leave without the loss of status.

19 ~~112.~~ Residency program directors must assist residents in identifying their specific
20 requirements (for example, the number of months to be made up) because of leave for
21 eligibility for board certification and must notify residents on leave if they are in danger of
22 falling below minimal requirements for board eligibility. Program directors must give these
23 residents a complete list of requirements to be completed in order to retain board eligibility.

24 ~~1213.~~ Our AMA encourages flexibility in residency training programs, incorporating
25 parental leave and alternative schedules for pregnant house staff.

26 ~~1314.~~ In order to accommodate leave protected by the federal Family and Medical Leave
27 Act, our AMA encourages all specialties within the American Board of Medical Specialties
28 to allow graduating residents to extend training up to 12 weeks after the traditional
29 residency completion date while still maintaining board eligibility in that year.

30 ~~1415.~~ These policies as above should be freely available online and in writing to all
31 applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

32
33 Your Reference Committee reviewed live and online testimony regarding Resolutions 302,
34 303, and 308. These items were heard separately during the hearing, and are combined
35 here because all three recommend changes to Policy H-405.960 (with 302 also proposing
36 edits to H-420.979). The authors of Resolution 302 testified in strong support of the need
37 to amend current policy to include miscarriage and stillbirth as part of employee leave to
38 allow time for the affected families to heal and cope with these tragic and traumatic
39 experiences. Testimony was received requesting that abortion, the medical terminology
40 for miscarriage, be used in AMA policy. Your Reference Committee concurs with this
41 testimony and has revised the policy throughout, as noted. While acknowledging the
42 sensitivity of the issue, the term abortion is standard medical terminology and therefore
43 your Reference Committee supports its use in AMA policy.

44
45 For Resolution 303, the authors called for a universal leave policy for all medical schools
46 to protect and promote the health of both parent and child. This is particularly of
47 importance as child-bearing years align with career development years, with inevitable
48 conflicts and challenges arising thereof. Testimony was supportive of adoption and offered

1 an amendment to Section 8, subsection D to change the word “without” to “with minimal
2 or no delay.” The Council on Medical Education, meanwhile, expressed its support for
3 substitute language for clause 8, to allow for medical schools to create more generalized
4 and flexible policy that can be tailored to students’ specific situations and in concordance
5 with the institution’s curricular requirements.

6
7 For Resolution 308, testimony was predominately supportive, particularly for the proposed
8 increase in paid parental, family and medical necessity leave from 6 to 12 weeks. The
9 Council on Medical Education recommended that clause 4 of this resolution be studied,
10 given the impacts of leave on competency and medical practice.

11
12 (5) RESOLUTION 305 – ENCOURAGING MEDICAL
13 SCHOOLS TO SPONSOR PIPELINE PROGRAMS TO
14 MEDICINE FOR UNDERREPRESENTED GROUPS

15
16 **RECOMMENDATION A:**

17
18 **The first Resolve of Resolution 305 be amended by**
19 **addition and deletion, to read as follows:**

20
21 **RESOLVED, That our American Medical Association**
22 **urge medical schools to develop or expand the reach of**
23 **existing pipeline pathway programs for**
24 **underrepresented middle school, high school and**
25 **college aged students to motivate them to pursue and**
26 **prepare them for a career in medicine (New HOD**
27 **Policy); and be it further**

28
29 **RECOMMENDATION B:**

30
31 **The third Resolve of Resolution 305 be amended by**
32 **addition and deletion, to read as follows:**

33
34 **RESOLVED, That our AMA recommend that medical**
35 **school pipeline pathway programs for**
36 **underrepresented students be free-of-charge or**
37 **provide financial support with need-based scholarships**
38 **and grants (New HOD Policy); and be it further**

39
40 **RECOMMENDATION C:**

41
42 **Resolution 305 be adopted as amended.**

43
44 **HOD ACTION: Resolution 305 adopted as amended**

45
46 **Resolution 305 be amended by addition of a fifth Resolve,**
47 **to read as follows:**

1 **RESOLVED, That our AMA consider quality of K-12**
2 **education a social determinant of health and thus advocate**
3 **for implementation of Policy H-350.979, (1) (a) encouraging**
4 **state and local governments to make quality elementary and**
5 **secondary education available to all.**

6
7 The title of Resolution 305 be amended, to read as follows:

8
9 **ENCOURAGING MEDICAL SCHOOLS TO SPONSOR**
10 **PATHWAY PROGRAMS TO MEDICINE FOR**
11 **UNDERREPRESENTED GROUPS**

12
13 RESOLVED, That our American Medical Association urge medical schools to develop or
14 expand the reach of existing pipeline programs for underrepresented middle school, high
15 school and college aged students to motivate them to pursue and prepare them for a
16 career in medicine (New HOD Policy); and be it further

17
18 RESOLVED, That our AMA encourage collegiate programs to establish criteria by which
19 completion of such programs will secure an interview for admission to the sponsoring
20 medical school (New HOD Policy); and be it further

21
22 RESOLVED, That our AMA recommend that medical school pipeline programs for
23 underrepresented students be free-of-charge or provide financial support with need-based
24 scholarships and grants (New HOD Policy); and be it further

25
26 RESOLVED, That our AMA encourage all physicians to actively participate in programs
27 and mentorship opportunities that help expose underrepresented students to potential
28 careers in medicine. (New HOD Policy)

29
30 Your Reference Committee reviewed live and online testimony regarding this item.
31 Testimony expressed support for both the downstream recommendations made by the
32 authors as well as suggested amendments to incorporate upstream interventions such as
33 encouraging governmental support for quality Kindergarten through 12th grade education
34 as a social determinant of health and as a method to increase the number of qualified
35 applicants to medical school. Your Reference Committee felt that this request was beyond
36 the scope of this proposed policy. A friendly amendment was also offered to update the
37 nomenclature for programs aimed at increasing access to medical education among those
38 who have been historically excluded to “pathway” programs as referenced in an earlier
39 Council on Medical Education Report to demonstrate there are many ways to enter the
40 field of medicine and away from the perspective associated with “pipeline,” a metaphor
41 that implies a rigid and reductionist perspective. This verbiage may also give rise to
42 negative connotations for Native Americans (that is, the all-too-common despoilation of
43 their ancestral lands by pipelines, distended with petroleum and other hazardous
44 substances). Therefore, your Reference Committee recommends that Resolution 305 be
45 adopted as amended.

1 (6) RESOLUTION 306 – INCREASED CREDIT FOR
2 CONTINUING MEDICAL EDUCATION PREPARATION
3

4 **RECOMMENDATION A:**

5
6 **Resolution 306 be amended by addition and deletion, to**
7 **read as follows:**
8

9 **RESOLVED, That our American Medical Association,**
10 **through its AMA-PRA credit system, collaborate with**
11 **the Accreditation Council on Continuing Medical**
12 **Education (ACCME), to allow physicians to claim an**
13 **amount of Category 1 CME credits that more accurately**
14 **reflects the learning associated with preparing and**
15 **presenting CME programs, Physicians may claim**
16 **minimum of up to four (4) Category 1 CME hours per**
17 **each hour of presentation. (Directive to Take Action).**
18

19 **RECOMMENDATION B:**

20
21 **Resolution 306 be adopted as amended.**
22

23 **HOD ACTION: Resolution 306 adopted as amended**
24

25 RESOLVED, That our American Medical Association collaborate with the Accreditation
26 Council on Continuing Medical Education (ACCME), to allow physicians to claim an
27 amount of Category 1 CME credits that more accurately reflects the hours they spend on
28 preparing and presenting CME programs to a maximum of four (4) Category 1 CME hours.
29 (Directive to Take Action)
30

31 Your Reference Committee reviewed live and online testimony regarding this item.
32 Testimony was unanimously supportive of this resolution. Testimony from the Council on
33 Medical Education provided important background information on the claiming of
34 continuing medical education (CME) credit, including the reminder that the number of
35 Category 2 CME credits that can be claimed is not limited, as long as the activity meets
36 the stipulated requirements in the AMA Physician's Recognition Award (AMA PRA)
37 booklet, and that this would be a mechanism for declaring actual hours spent. The Council
38 proffered amendments to in effect double the number of Category 1 credits that could be
39 claimed per hour of time preparing and presenting a CME program. As the owner of the
40 AMA PRA credit system, our AMA is entitled to make this change without the need to
41 collaborate with the Accreditation Council for Continuing Medical Education which was
42 reflected in the Council's additional edit to remove that ask from the resolution. Therefore,
43 your Reference Committee recommends that Resolution 306 be adopted as amended.

1 (7) RESOLUTION 309 – BEREAVEMENT LEAVE FOR
2 MEDICAL STUDENTS AND PHYSICIANS
3

4 **RECOMMENDATION A:**
5

6 **Resolution 309 be amended by addition and deletion, to**
7 **read as follows:**
8

9 **RESOLVED, That our American Medical Association**
10 **support ~~bereavement~~ compassionate leave for medical**
11 **students and physicians:**
12

13 **1. Our AMA urges medical schools, residency and**
14 **fellowship training programs, medical specialty boards,**
15 **the Accreditation Council for Graduate Medical**
16 **Education, and medical group practices to incorporate**
17 **and/or encourage development of ~~bereavement~~**
18 **compassionate leave policies as part of the physician's**
19 **standard benefit agreement.**
20

21 **2. Our AMA will study Recommended components of**
22 **~~bereavement~~ compassionate leave policies for medical**
23 **students and physicians, to include:**

- 24 **a. whether cases requiring extensive travel qualify for**
25 **additional days of leave and, if so, how many days;**
26 **b. policy and duration of leave for an event impacting**
27 **pregnancy or fertility including pregnancy loss, an**
28 **unsuccessful round of intrauterine insemination or of**
29 **an assisted reproductive technology procedure, a failed**
30 **adoption arrangement, a failed surrogacy arrangement,**
31 **or an event that impacts pregnancy or fertility;**
32 **c. whether leave is paid or unpaid;**
33 **d. whether obligations and time must be made up; and**
34 **e. whether make-up time will be paid.**
35

36 **3. Our AMA encourages medical schools, residency**
37 **and fellowship programs, specialty boards, specialty**
38 **societies and medical group practices to incorporate**
39 **into their ~~bereavement~~ compassionate leave policies a**
40 **three-day minimum leave, with the understanding that**
41 **no medical student or physician or ~~medical student~~**
42 **should be required to take a minimum leave.**
43

44 **4. Medical students and physicians who are unable to**
45 **work beyond the defined ~~bereavement~~ compassionate**
46 **leave period because of physical or psychological**
47 **stress, medical complications of pregnancy loss, or**
48 **another related reason should refer to their institution's**

1 sick leave policy, family and medical leave policy, and
2 other benefits on the same basis as other physicians
3 who are temporarily unable to work for other reasons.
4

5 **5. Our AMA ~~supports~~ will study the concept of equal
6 bereavement compassionate leave for pregnancy loss
7 and other such events impacting fertility in a physician
8 or their partner as a benefit for medical students and
9 physicians regardless of gender or gender identity.**

10
11 **6. Staffing levels and scheduling are encouraged to be
12 flexible enough to allow for coverage without creating
13 intolerable increases in the workloads of other
14 physicians, particularly those in residency programs.**

15
16 **7. These guidelines as above should be freely available
17 online and in writing to all applicants to medical school,
18 residency, or fellowship. (Directive to Take Action)**

19
20 **RECOMMENDATION B:**

21
22 **Resolution 309 be adopted as amended.**

23
24 **HOD ACTION: Resolution 309 adopted as amended**

25
26 RESOLVED, That our American Medical Association support bereavement leave for
27 medical students and physicians:

28 1. Our AMA urges medical schools, residency and fellowship training
29 programs, medical specialty boards, the Accreditation Council for
30 Graduate Medical Education, and medical group practices to incorporate and/or
31 encourage development of bereavement leave policies as part of the physician's standard
32 benefit agreement.

33 2. Recommended components of bereavement leave policies for medical students and
34 physicians include:

35 a. whether cases requiring extensive travel qualify for additional days of leave and, if so,
36 how many days;

37 b. policy and duration of leave for an event impacting pregnancy or fertility including
38 pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted
39 reproductive technology procedure, a failed adoption arrangement, a failed surrogacy
40 arrangement, or an event that impacts pregnancy or fertility;

41 c. whether leave is paid or unpaid;

42 d. whether obligations and time must be made up; and

43 e. whether make-up time will be paid.

44 3. Our AMA encourages medical schools, residency and fellowship programs, specialty
45 boards, specialty societies and medical group practices to incorporate into their
46 bereavement leave policies a three-day minimum leave, with the understanding that no
47 physician or medical student should be required to take a minimum leave.

1 4. Medical students and physicians who are unable to work beyond the defined
2 bereavement leave period because of physical or psychological stress, medical
3 complications of pregnancy loss, or another related reason should refer to their institution's
4 sick leave policy, family and medical leave policy, and other benefits on the same basis
5 as other physicians who are temporarily unable to work for other reasons.

6 5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and
7 other such events impacting fertility in a physician or their partner as a benefit for
8 medical students and physicians regardless of gender or gender identity.

9 6. Staffing levels and scheduling are encouraged to be flexible enough to allow for
10 coverage without creating intolerable increases in the workloads of other physicians,
11 particularly those in residency programs.

12 7. These guidelines as above should be freely available online and in writing to all
13 applicants to medical school, residency, or fellowship. (Directive to Take Action)

14
15 Your Reference Committee reviewed live and online testimony regarding this item. While
16 the majority of testimony was supportive, there was sentiment in support of referral, as
17 bereavement is not considered a component of family medical leave. Additionally,
18 testimony expressed concern that "bereavement" could intimate "personhood," with an
19 amendment offered to replace "bereavement" with "compassionate" throughout the
20 resolution, including the title. Your Reference Committee appreciates that the issues
21 associated with this resolution are complex and believes that clauses 2 and 5 of the
22 resolution require a comprehensive review to formulate a comprehensive policy—hence,
23 the recommendation for our AMA to study these issues further. Therefore, your Reference
24 Committee recommends that Resolution 309 be adopted as amended.

25
26 (8) RESOLUTION 310 – ENFORCE AMA PRINCIPLES ON
27 CONTINUING BOARD CERTIFICATION

28
29 **RECOMMENDATION A:**

30
31 **Policy H-275.924 be reaffirmed in lieu of the first**
32 **Resolve of Resolution 310.**

33
34 **RECOMMENDATION B:**

35
36 **The second Resolve of Resolution 310 be amended by**
37 **addition and deletion, to read as follows:**

38
39 **RESOLVED, That our AMA continue to publicly report**
40 **their its work on enforcing AMA Principles on**
41 **Continuing Board Certification at the Annual and**
42 **Interim meetings of the AMA House of Delegates.**
43 **(Directive to Take Action)**

44
45 **RECOMMENDATION C:**

46
47 **Resolution 310 be adopted as amended.**

HOD ACTION: Resolution 310 adopted as amended

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)

Your Reference Committee reviewed live and online testimony regarding this item. Testimony from the Council on Medical Education recommended that AMA policy be reaffirmed in lieu of the first resolve, and that the second resolve be amended to reinforce the value of the AMA's core principles on continuing board certification (CBC) and remove references to timing of a report back. Further testimony was supportive of the Council's recommendations. Your Reference Committee appreciates that the Council will continue to monitor this important subject, as some testimony noted continued concerns about CBC, particularly among specific specialties. Your Reference Committee concurs with the Council's recommendations to the first and second resolves and clarifies that the AMA's core principles on CBC, namely, H-275.924, be reaffirmed in lieu of the first resolve. Therefore, your Reference Committee recommends that Resolution 310 be adopted as amended.

Policy recommended for reaffirmation:**H-275.924, "Continuing Board Certification"**

AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

- 1 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare
2 Providers and Systems (CAHPS) patient survey are neither appropriate nor
3 effective survey tools to assess physician competence in many specialties.
4
- 5 7. Careful consideration should be given to the importance of retaining flexibility in
6 pathways for CBC for physicians with careers that combine clinical patient care
7 with significant leadership, administrative, research and teaching responsibilities.
8
- 9 8. Legal ramifications must be examined, and conflicts resolved, prior to data
10 collection and/or displaying any information collected in the process of CBC.
11 Specifically, careful consideration must be given to the types and format of
12 physician-specific data to be publicly released in conjunction with CBC
13 participation.
14
- 15 9. Our AMA affirms the current language regarding continuing medical education
16 (CME): “Each Member Board will document that diplomates are meeting the CME
17 and Self-Assessment requirements for CBC Part II. The content of CME and self-
18 assessment programs receiving credit for CBC will be relevant to advances within
19 the diplomate’s scope of practice, and free of commercial bias and direct support
20 from pharmaceutical and device industries. Each diplomate will be required to
21 complete CME credits (AMA PRA Category 1 Credit”, American Academy of
22 Family Physicians Prescribed, American College of Obstetricians and
23 Gynecologists, and/or American Osteopathic Association Category 1A).”
24
- 25 10. In relation to CBC Part II, our AMA continues to support and promote the AMA
26 Physician’s Recognition Award (PRA) Credit system as one of the three major
27 credit systems that comprise the foundation for continuing medical education in
28 the U.S., including the Performance Improvement CME (PICME) format; and
29 continues to develop relationships and agreements that may lead to standards
30 accepted by all U.S. licensing boards, specialty boards, hospital credentialing
31 bodies and other entities requiring evidence of physician CME.
32
- 33 11. CBC is but one component to promote patient safety and quality. Health care
34 is a team effort, and changes to CBC should not create an unrealistic expectation
35 that lapses in patient safety are primarily failures of individual physicians.
36
- 37 12. CBC should be based on evidence and designed to identify performance gaps
38 and unmet needs, providing direction and guidance for improvement in physician
39 performance and delivery of care.
- 40 13. The CBC process should be evaluated periodically to measure physician
41 satisfaction, knowledge uptake and intent to maintain or change practice.
42
- 43 14. CBC should be used as a tool for continuous improvement.
44
- 45 15. The CBC program should not be a mandated requirement for licensure,
46 credentialing, recredentialing, privileging, reimbursement, network participation,
47 employment, or insurance panel participation.

- 1 16. Actively practicing physicians should be well-represented on specialty boards
2 developing CBC.
- 3
- 4 17. Our AMA will include early career physicians when nominating individuals to
5 the Boards of Directors for ABMS member boards.
- 6
- 7 18. CBC activities and measurement should be relevant to clinical practice.
- 8
- 9 19. The CBC process should be reflective of and consistent with the cost of
10 development and administration of the CBC components, ensure a fair fee
11 structure, and not present a barrier to patient care.
- 12
- 13 20. Any assessment should be used to guide physicians' self-directed study.
- 14
- 15 21. Specific content-based feedback after any assessment tests should be
16 provided to physicians in a timely manner.
- 17
- 18 22. There should be multiple options for how an assessment could be structured
19 to accommodate different learning styles.
- 20
- 21 23. Physicians with lifetime board certification should not be required to seek
22 recertification.
- 23
- 24 24. No qualifiers or restrictions should be placed on diplomates with lifetime board
25 certification recognized by the ABMS related to their participation in CBC.
- 26
- 27 25. Members of our House of Delegates are encouraged to increase their
28 awareness of and participation in the proposed changes to physician self-
29 regulation through their specialty organizations and other professional
30 membership groups.
- 31
- 32 26. The initial certification status of time-limited diplomates shall be listed and
33 publicly available on all American Board of Medical Specialties (ABMS) and ABMS
34 Member Boards websites and physician certification databases. The names and
35 initial certification status of time-limited diplomates shall not be removed from
36 ABMS and ABMS Member Boards websites or physician certification databases
37 even if the diplomate chooses not to participate in CBC.
- 38
- 39 27. Our AMA will continue to work with the national medical specialty societies to
40 advocate for the physicians of America to receive value in the services they
41 purchase for Continuing Board Certification from their specialty boards. Value in
42 CBC should include cost effectiveness with full financial transparency, respect for
43 physicians' time and their patient care commitments, alignment of CBC
44 requirements with other regulator and payer requirements, and adherence to an
45 evidence basis for both CBC content and processes.

1 (9) RESOLUTION 312 – REPORTING OF RESIDENCY
2 DEMOGRAPHIC DATA
3

4 **RECOMMENDATION A:**

5
6 **The first Resolve of Resolution 312 be amended by**
7 **addition and deletion, to read as follows:**
8

9 **RESOLVED, That our American Medical Association**
10 **work with appropriate stakeholders to encourage that**
11 **residency programs annually publish and share with**
12 **FREIDA and other appropriate stakeholders, (a) self-**
13 **identified and other demographic data, including but**
14 **not limited to the composition of their program over the**
15 **last 5 years by age;**~~16 **gender identity;**~~
17 ~~18 **URM historically**~~
19 ~~20 **marginalized, minoritized, or excluded status;**~~
21 ~~21 **sexual**~~
22 ~~22 **orientation and gender identity;**~~
23 ~~23 **and LGBTQIA+ status;**~~
24 ~~24 **(b) parental and family leave policies;**~~
25 ~~25 **and (c) the**~~
26 ~~26 **number and/or proportion of residents who have**~~
27 ~~27 **utilized parental or family leave in the past 5 years**~~
28 ~~28 **(Directive to Take Action); and be it further**~~

29 **RECOMMENDATION B:**

30
31 **The second Resolve of Resolution 312 be amended by**
32 **deletion, to read as follows:**
33

34 **RESOLVED, That our AMA encourage the Accreditation**
35 **Council for Graduate Medical Education and other**
36 **relevant stakeholders to annually collect data on**
37 **pregnancy,**
38 **childbirth,**
39 **and parenthood from all**
40 **accredited US residency programs and publish this**
41 **data with disaggregation by gender identity and**
42 **specialty. (New HOD Policy)**

43 **RECOMMENDATION C:**

44
45 **Policy H-405.960 be amended by addition, to read as**
46 **follows:**
47

48 **AMA adopts as policy the following guidelines for, and**
49 **encourages the implementation of, Parental, Family and**
50 **Medical Necessity Leave for Medical Students and**
51 **Physicians:**

52 **1. Our AMA urges medical schools, residency training**
53 **programs, medical specialty boards, the Accreditation**
54 **Council for Graduate Medical Education, and medical**
55 **group practices to incorporate and/or encourage**

- 1 development of leave policies, including parental,
2 family, and medical leave policies, as part of the
3 physician's standard benefit agreement.
- 4 2. Recommended components of parental leave
5 policies for medical students and physicians include:
6 (a) duration of leave allowed before and after delivery;
7 (b) category of leave credited; (c) whether leave is paid
8 or unpaid; (d) whether provision is made for
9 continuation of insurance benefits during leave, and
10 who pays the premium; (e) whether sick leave and
11 vacation time may be accrued from year to year or used
12 in advance; (f) how much time must be made up in order
13 to be considered board eligible; (g) whether make-up
14 time will be paid; (h) whether schedule
15 accommodations are allowed; and (i) leave policy for
16 adoption.
- 17 3. AMA policy is expanded to include physicians in
18 practice, reading as follows: (a) residency program
19 directors and group practice administrators should
20 review federal law concerning maternity leave for
21 guidance in developing policies to assure that pregnant
22 physicians are allowed the same sick leave or disability
23 benefits as those physicians who are ill or disabled; (b)
24 staffing levels and scheduling are encouraged to be
25 flexible enough to allow for coverage without creating
26 intolerable increases in other physicians' workloads,
27 particularly in residency programs; and (c) physicians
28 should be able to return to their practices or training
29 programs after taking parental leave without the loss of
30 status.
- 31 4. Our AMA encourages medical schools, residency
32 programs, specialty boards, and medical group
33 practices to incorporate into their parental leave
34 policies a six-week minimum leave allowance, with the
35 understanding that no parent should be required to take
36 a minimum leave.
- 37 5. Residency program directors should review federal
38 and state law for guidance in developing policies for
39 parental, family, and medical leave.
- 40 6. Medical students and physicians who are unable to
41 work because of pregnancy, childbirth, and other
42 related medical conditions should be entitled to such
43 leave and other benefits on the same basis as other
44 physicians who are temporarily unable to work for other
45 medical reasons.
- 46 7. Residency programs should develop written policies
47 on parental leave, family leave, and medical leave for
48 physicians. Such written policies should include the

1 following elements: (a) leave policy for birth or
2 adoption; (b) duration of leave allowed before and after
3 delivery; (c) category of leave credited (e.g., sick,
4 vacation, parental, unpaid leave, short term disability);
5 (d) whether leave is paid or unpaid; (e) whether
6 provision is made for continuation of insurance
7 benefits during leave and who pays for premiums; (f)
8 whether sick leave and vacation time may be accrued
9 from year to year or used in advance; (g) extended leave
10 for resident physicians with extraordinary and long-
11 term personal or family medical tragedies for periods of
12 up to one year, without loss of previously accepted
13 residency positions, for devastating conditions such as
14 terminal illness, permanent disability, or complications
15 of pregnancy that threaten maternal or fetal life; (h) how
16 time can be made up in order for a resident physician
17 to be considered board eligible; (i) what period of leave
18 would result in a resident physician being required to
19 complete an extra or delayed year of training; (j)
20 whether time spent in making up a leave will be paid;
21 and (k) whether schedule accommodations are allowed,
22 such as reduced hours, no night call, modified rotation
23 schedules, and permanent part-time scheduling.

24 8. Our AMA endorses the concept of equal parental
25 leave for birth and adoption as a benefit for resident
26 physicians, medical students, and physicians in
27 practice regardless of gender or gender identity.

28 9. Staffing levels and scheduling are encouraged to be
29 flexible enough to allow for coverage without creating
30 intolerable increases in the workloads of other
31 physicians, particularly those in residency programs.

32 10. Physicians should be able to return to their
33 practices or training programs after taking parental
34 leave, family leave, or medical leave without the loss of
35 status.

36 11. Residency program directors must assist residents
37 in identifying their specific requirements (for example,
38 the number of months to be made up) because of leave
39 for eligibility for board certification and must notify
40 residents on leave if they are in danger of falling below
41 minimal requirements for board eligibility. Program
42 directors must give these residents a complete list of
43 requirements to be completed in order to retain board
44 eligibility.

45 12. Our AMA encourages flexibility in residency training
46 programs, incorporating parental leave and alternative
47 schedules for pregnant house staff.

1 **13. In order to accommodate leave protected by the**
2 **federal Family and Medical Leave Act, our AMA**
3 **encourages all specialties within the American Board of**
4 **Medical Specialties to allow graduating residents to**
5 **extend training up to 12 weeks after the traditional**
6 **residency completion date while still maintaining board**
7 **eligibility in that year.**

8 **14. These policies as above should be freely available**
9 **online through FREIDA and in writing to all applicants**
10 **to medical school, residency or fellowship.**

11
12 **RECOMMENDATION D:**

13
14 **Resolution 312 be adopted as amended.**

15
16 **HOD ACTION: Resolution 312 adopted as amended**

17
18 RESOLVED, That our American Medical Association work with appropriate stakeholders
19 to encourage that residency programs annually publish and share with FREIDA and other
20 appropriate stakeholders, (a) demographic data, including but not limited to the
21 composition of their program over the last 5 years by age, gender identity, URM status,
22 and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or
23 proportion of residents who have utilized parental or family leave in the past 5 years
24 (Directive to Take Action); and be it further

25
26 RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical
27 Education and other relevant stakeholders to annually collect data on pregnancy,
28 childbirth, and parenthood from all accredited US residency programs and publish this
29 data with disaggregation by gender identity and specialty. (New HOD Policy)

30
31 Your Reference Committee heard supportive testimony for the intent of this item, which is
32 intended to encourage transparency. The author noted the value in having such data
33 available during the decision-making process, while also acknowledging the importance
34 of protecting privacy. Regarding clause (a) of the first resolve, your Reference Committee
35 discussed the sensitivity of some of the data listed in the first resolve and therefore
36 recommended that “self-identified” be added. Further, your Reference Committee
37 recommended reordering the data points such that “gender identity” and “sexual
38 orientation” are adjacent, and recommended changing “URM” to “historically marginalized,
39 minoritized, or excluded,” in keeping with the AMA and AAMC’s resource, “Advancing
40 Health Equity: A Guide to Language, Narrative and Concepts.” In lieu of clause (b), your
41 Reference Committee recommends that AMA Policy H-405.960 be amended to include
42 “FREIDA.” Your Reference Committee also recommends striking clause (c) due to legal
43 and privacy concerns.

44
45 Regarding the second resolve, your Reference Committee recommends that “pregnancy”
46 be stricken, given the privacy concerns and inappropriate nature of requesting this
47 information. With these revisions, your Reference Committee recommends that
48 Resolution 312 be adopted as amended.

1 (10) RESOLUTION 313 – REQUEST A TWO-YEAR DELAY IN
2 ACCME CHANGES TO STATE MEDICAL SOCIETY
3 RECOGNITION PROGRAM
4

5 **RECOMMENDATION A:**
6

7 **Resolution 313 be amended by addition and deletion, to**
8 **read as follows:**
9

10 **RESOLVED, That our American Medical Association**
11 **collaborate with Accreditation Council for Continuing**
12 **Medical Education (ACCME) ~~with a goal to secure a two-~~**
13 **~~year delay in the implementation of any changes to the~~**
14 **state medical society accreditor program until such**
15 **time that a mutual agreement can be reached. During**
16 **that time, AMA, ACCME and state medical societies will**
17 **work collaboratively to study the impact and**
18 **unintended consequences of the proposed action and**
19 **to create a plan that is in the best interests of all parties,**
20 **including the continuing medical education providers**
21 **currently accredited by state medical societies.**
22 **(Directive to Take Action)**
23

24 **RECOMMENDATION B:**
25

26 **Resolution 313 be adopted as amended.**
27

28 **HOD ACTION: Resolution 313 adopted as amended**
29

30 RESOLVED, That our American Medical Association collaborate with Accreditation
31 Council for Continuing Medical Education (ACCME) with a goal to secure a two-year delay
32 in the implementation of any changes to the state medical society accreditor program.
33 During that time, AMA, ACCME and state medical societies will work collaboratively to
34 study the impact and unintended consequences of the proposed action and to create a
35 plan that is in the best interests of all parties, including the continuing medical education
36 providers currently accredited by state medical societies. (Directive to Take Action)
37

38 Your Reference Committee reviewed live and online testimony regarding this item. Online
39 testimony from the Accreditation Council for Continuing Medical Education (ACCME)
40 noted that this topic will be addressed as a key agenda item at its annual meeting with the
41 state medical societies next month; therefore, they asked that the AMA not act on this
42 resolution at this time. Further testimony supportive of the resolution expressed several
43 concerns, such as the impact on education in rural areas and in less populous states; the
44 arbitrary nature of the ACCME's proposed changes to the state medical society programs
45 and lack of data linking the number of programs in a given state to the quality of these
46 programs; and an implementation date that does not allow sufficient time for affected
47 states to assess and address the impact of the proposed changes. Testimony expressed
48 urgency to address this matter. Your Reference Committee concurs with the concerns

1 raised and recommends striking “two-year” and adding language requiring mutual
2 agreement among all parties. Therefore, your Reference Committee recommends that
3 Resolution 313 be adopted as amended.

4
5 (11) RESOLUTION 316 – RECOGNIZING SPECIALTY
6 CERTIFICATIONS FOR PHYSICIANS

7
8 **RECOMMENDATION A:**

9
10 **The first Resolve of Resolution 316 be amended by**
11 **addition and deletion, to read as follows:**

12
13 **RESOLVED, That our American Medical Association**
14 **amend Policy H-275.926, “Medical Specialty Board**
15 **Certification Standards,” by addition to read as follows:**

16
17 **(1) Opposes any action, regardless of intent, that**
18 **appears likely to confuse the public about the unique**
19 **credentials of American Board of Medical Specialties**
20 **(ABMS) or American Osteopathic Association Bureau**
21 **of Osteopathic Specialists (AOA-BOS) board certified**
22 **physicians in any medical specialty, or take advantage**
23 **of the prestige of any medical specialty for purposes**
24 **contrary to the public good and safety.**

25 **(2) Opposes any action, regardless of intent, by**
26 **organizations providing board certification for non-**
27 **physicians that appears likely to confuse the public**
28 **about the unique credentials of medical specialty board**
29 **certification or take advantage of the prestige of**
30 **medical specialty board certification for purposes**
31 **contrary to the public good and safety.**

32 **(3) Continues to work with other medical**
33 **organizations to educate the profession and the public**
34 **about the ABMS and AOA-BOS board certification**
35 **process. It is AMA policy that when the equivalency of**
36 **board certification must be determined, the certification**
37 **program must first meet industry accepted standards**
38 **for certification that include both 1) a process for**
39 **defining specialty-specific standards for knowledge**
40 **and skills and 2) offer an independent, external**
41 **assessment of knowledge and skills for both initial**
42 **certification and recertification in the medical specialty.**
43 **In addition, accepted standards, such as those adopted**
44 **by state medical boards or the Essentials for Approval**
45 **of Examining Boards in Medical Specialties, will**
46 **be utilized for that determination.**

47 **(4) Opposes discrimination against physicians**
48 **based solely on lack of ABMS or equivalent AOA-BOS**

1 board certification, or where board certification is one
2 of the criteria considered for purposes of measuring
3 quality of care, determining eligibility to contract with
4 managed care entities, eligibility to receive hospital
5 staff or other clinical privileges, ascertaining
6 competence to practice medicine, or for other
7 purposes. Our AMA also opposes discrimination that
8 may occur against physicians involved in the board
9 certification process, including those who are in a
10 clinical practice period for the specified minimum
11 period of time that must be completed prior to taking
12 the board certifying examination.

13 (5) Advocates for nomenclature to better
14 distinguish those physicians who are in the board
15 certification pathway from those who are not.

16 (6) Encourages member boards of the ABMS to
17 adopt measures aimed at mitigating the financial
18 burden on residents related to specialty board fees and
19 fee procedures, including shorter preregistration
20 periods, lower fees and easier payment terms. (Modify
21 Current HOD Policy); and be it further
22

23 RECOMMENDATION B:

24
25 The second Resolve of Resolution 316 be amended by
26 addition and deletion, to read as follows:
27

28 RESOLVED, that our AMA advocate for federal and
29 state legislatures, federal and state regulators,
30 physician credentialing organizations, hospitals, and
31 other health care stakeholders ~~and the public~~ to define
32 physician board certification as establishing specialty-
33 specific standards for knowledge and skills, using an
34 independent assessment process to determine the
35 acquisition of knowledge and skills for initial
36 certification and recertification. (Directive to Take
37 Action)
38

39 RECOMMENDATION C:

40
41 Resolution 316 be adopted as amended.
42

43 HOD ACTION: Resolution 316 adopted as amended
44

45 The first Resolve of Resolution 316 be amended by
46 addition and deletion, to read as follows:

1 **RESOLVED, That our American Medical Association**
2 **amend Policy H-275.926, “Medical Specialty Board**
3 **Certification Standards,” by addition, to read as**
4 **follows:**

- 5
- 6 **(1) Opposes any action, regardless of intent, that appears**
7 **likely to confuse the public about the unique credentials**
8 **of American Board of Medical Specialties (ABMS) or**
9 **American Osteopathic Association Bureau of**
10 **Osteopathic Specialists (AOA-BOS) board certified**
11 **physicians in any medical specialty, or take advantage**
12 **of the prestige of any medical specialty for purposes**
13 **contrary to the public good and safety.**
- 14 **(2) Opposes any action, regardless of intent, by**
15 **organizations providing board certification for non-**
16 **physicians that appears likely to confuse the public**
17 **about the unique credentials of medical specialty board**
18 **certification or take advantage of the prestige of**
19 **medical specialty board certification for purposes**
20 **contrary to the public good and safety.**
- 21 **(3) Continues to work with other medical organizations to**
22 **educate the profession and the public about the ABMS**
23 **and AOA-BOS board certification process. It is AMA**
24 **policy that when the equivalency of board certification**
25 **must be determined, the certification program must**
26 **first meet industry accepted standards for certification**
27 **that include both 1) a process for defining specialty-**
28 **specific standards for knowledge and skills and 2) offer**
29 **an independent, external assessment of knowledge and**
30 **skills for both initial certification and recertification or**
31 **continuous certification in the medical specialty. In**
32 **addition, accepted standards, such as those adopted**
33 **by state medical boards or the Essentials for Approval**
34 **of Examining Boards in Medical Specialties, will**
35 **be utilized for that determination.**
- 36 **(4) Opposes discrimination against physicians based**
37 **solely on lack of ABMS or equivalent AOA-BOS board**
38 **certification, or where board certification is one of the**
39 **criteria considered for purposes of measuring quality of**
40 **care, determining eligibility to contract with managed**
41 **care entities, eligibility to receive hospital staff or other**
42 **clinical privileges, ascertaining competence to practice**
43 **medicine, or for other purposes. Our AMA also opposes**
44 **discrimination that may occur against physicians**
45 **involved in the board certification process, including**
46 **those who are in a clinical practice period for the**
47 **specified minimum period of time that must be**

1 completed prior to taking the board certifying
2 examination.

3 (5) Advocates for nomenclature to better distinguish those
4 physicians who are in the board certification pathway
5 from those who are not.

6 (6) Encourages member boards of the ABMS to adopt
7 measures aimed at mitigating the financial burden on
8 residents related to specialty board fees and fee
9 procedures, including shorter preregistration periods,
10 lower fees and easier payment terms. (Modify Current
11 HOD Policy); and be it further

12
13 The second Resolve of Resolution 316 be referred.

14
15 RESOLVED, That our American Medical Association amend Policy H-275.926, "Medical
16 Specialty Board Certification Standards," by addition to read as follows:

- 17 1) Opposes any action, regardless of intent, that appears likely to confuse the public
18 about the unique credentials of American Board of Medical Specialties (ABMS) or
19 American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)
20 board certified physicians in any medical specialty, or take advantage of the
21 prestige of any medical specialty for purposes contrary to the public good and
22 safety.
- 23 2) Opposes any action, regardless of intent, by organizations providing board
24 certification for non-physicians that appears likely to confuse the public about the
25 unique credentials of medical specialty board certification or take advantage of the
26 prestige of medical specialty board certification for purposes contrary to the public
27 good and safety.
- 28 3) Continues to work with other medical organizations to educate the profession and
29 the public about the ABMS and AOA-BOS board certification process. It is AMA
30 policy that when the equivalency of board certification must be determined, the
31 certification program must first meet industry standards for certification that include
32 both 1) a process for defining specialty-specific standards for knowledge and skills
33 and 2) offer an independent, external assessment of knowledge and skills for both
34 initial certification and recertification in the medical specialty. In addition, accepted
35 standards, such as those adopted by state medical boards or the Essentials for
36 Approval of Examining Boards in Medical Specialties, will be utilized for that
37 determination.
- 38 4) Opposes discrimination against physicians based solely on lack of ABMS or
39 equivalent AOA-BOS board certification, or where board certification is one of the
40 criteria considered for purposes of measuring quality of care, determining eligibility
41 to contract with managed care entities, eligibility to receive hospital staff or other
42 clinical privileges, ascertaining competence to practice medicine, or for other
43 purposes. Our AMA also opposes discrimination that may occur against physicians
44 involved in the board certification process, including those who are in a clinical
45 practice period for the specified minimum period of time that must be completed
46 prior to taking the board certifying examination.
- 47 5) Advocates for nomenclature to better distinguish those physicians who are in the
48 board certification pathway from those who are not.

1 6) Encourages member boards of the ABMS to adopt measures aimed at mitigating
2 the financial burden on residents related to specialty board fees and fee
3 procedures, including shorter preregistration periods, lower fees and easier
4 payment terms. (Modify Current HOD Policy); and be it further

5
6 RESOLVED, that our AMA advocate for federal and state legislatures, federal and state
7 regulators, physician credentialing organizations, hospitals, other health care
8 stakeholders and the public to define physician board certification as establishing
9 specialty-specific standards for knowledge and skills, using an independent assessment
10 process to determine the acquisition of knowledge and skills for initial certification and
11 recertification. (Directive to Take Action)

12
13 Your Reference Committee reviewed live and online testimony regarding this item. Live
14 testimony expressed support for this resolution and acknowledged the complexities of this
15 issue. Further testimony recommended clarifying that this resolution addresses “initial and
16 continuing certification.” In clause (3) of the first resolve, your Reference Committee
17 recommended that the term “industry” be stricken, given its lack of definition, and replaced
18 by “accepted.” For the second resolve, testimony from the Council on Medical Education
19 recommended removal of “and the public”; the author concurred with this amendment.
20 Therefore, your Reference Committee recommends that Resolution 316 be adopted as
21 amended.

22
23 (12) RESOLUTION 317 - SUPPORT FOR GME TRAINING IN
24 REPRODUCTIVE SERVICES

25
26 **RECOMMENDATION A:**

27
28 **Resolution 317 be amended by addition and deletion, to**
29 **read as follows:**

30
31 RESOLVED, That AMA policy H-295.923, “Medical Training
32 and Termination of Pregnancy,” be amended by addition
33 and deletion, to read as follows:

34
35 **Medical Training and Termination of Pregnancy**

36
37 **1. Our AMA supports the education of medical students,**
38 **residents and young physicians about the need for**
39 **physicians who provide termination of pregnancy**
40 **services, the medical and public health importance of**
41 **access to safe termination of pregnancy, and the**
42 **medical, ethical, legal and psychological principles**
43 **associated with termination of pregnancy.**

44
45 **2. Our AMA supports will advocate for the availability of**
46 **abortion education and hands-on clinical exposure to**
47 **medication and procedural abortion procedures for**
48 **termination of pregnancy, including medication**

1 ~~abortions~~, for medical students and resident/fellow
2 physicians and opposes efforts to interfere with or
3 restrict the availability of this education and training.
4

5 3. In the event that medication and procedural abortion
6 are limited or illegal in a home institution, our AMA will
7 supports pathways for medical students and
8 resident/fellow physicians to receive this training at
9 another location, including cost subsidization, to
10 ensure trainees traveling to another program have
11 hands-on training in medication and procedural
12 abortion, and will advocate for legal protections for
13 both trainees who cross state lines to receive education
14 on reproductive health services, including medication
15 and procedural abortion, as well as the institutions
16 facilitating these opportunities.
17

18 4. Our AMA will advocate for funding for institutions
19 that provide clinical training on reproductive health
20 services, including medication and procedural
21 abortion, to medical students and resident/fellow
22 physicians from other programs, so that they can
23 expand their capacity to accept out-of-state medical
24 students and resident/fellow physicians seeking this
25 training.
26

27 35. Our AMA encourages the Accreditation Council for
28 Graduate Medical Education to consistently enforce
29 compliance with the standardization of abortion
30 training opportunities as per the requirements set forth
31 by the relevant Residency Review Committees Review
32 Committee for Obstetrics and Gynecology and the
33 American College of Obstetricians and Gynecologists'
34 recommendations; and be it further
35

36 RESOLVED, That our AMA reaffirm policies H-100.948
37 "Supporting Access to Mifepristone (Mifeprex)" and H-
38 425.969 "Support for Access to Preventive and
39 Reproductive Health Services"; and be it further
40

41 **RECOMMENDATION B:**

42
43 AMA Policy D-5.999 be amended by addition and
44 deletion, to read as follows:
45

46 RESOLVED, That AMA Policy D-5.999, "Preserving
47 Access to Reproductive Health Services," be amended
48 by addition, to read as follows:

1 **Our AMA: (1) recognizes that healthcare, including**
2 **reproductive health services like contraception and**
3 **abortion, is a human right; (2) opposes limitations on**
4 **access to evidence-based reproductive health services,**
5 **including fertility treatments, contraception, and**
6 **abortion; (3) will work with interested state medical**
7 **societies and medical specialty societies to vigorously**
8 **advocate for broad, equitable access to reproductive**
9 **health services, including fertility treatments,**
10 **contraception, and abortion; (4) supports shared**
11 **decision-making between patients and their physicians**
12 **regarding reproductive healthcare; (5) opposes any**
13 **effort to undermine the basic medical principle that**
14 **clinical assessments, such as viability of the pregnancy**
15 **and safety of the pregnant person, are determinations**
16 **to be made only by healthcare professionals with their**
17 **patients; (6) opposes the imposition of criminal and**
18 **civil penalties or other retaliatory efforts against**
19 **patients, patient advocates, physicians, other**
20 **healthcare workers, and health systems for receiving,**
21 **assisting in, referring patients to, or providing**
22 **reproductive health services; (7) will advocate for legal**
23 **protections for patients who cross state lines to receive**
24 **reproductive health services, including contraception**
25 **and abortion, or who receive medications for**
26 **contraception and abortion from across state lines, and**
27 **legal protections for those that provide, support, or**
28 **refer patients to these services; (8) will advocate for**
29 **legal protections for medical students and physicians**
30 **who cross state lines to receive education in or deliver**
31 **reproductive health services, including contraception**
32 **and abortion, and (89) will review the AMA policy**
33 **compendium and recommend policies which should be**
34 **amended or rescinded to reflect these core values, with**
35 **report back at the 2022 Interim Meeting.**

36
37 **RECOMMENDATION C:**

38
39 **Resolution 317 be adopted as amended.**

40
41 **HOD ACTION: Resolution 317 adopted as amended**

42
43 **RESOLVED, That AMA policy H-295.923, "Medical Training and Termination of**
44 **Pregnancy," be amended by addition and deletion to read as follows:**

45
46 **Medical Training and Termination of Pregnancy**

47 **1. Our AMA supports the education of medical students, residents and young**
48 **physicians about the need for physicians who provide termination of pregnancy**

1 services, the medical and public health importance of access to safe termination
2 of pregnancy, and the medical, ethical, legal and psychological principles
3 associated with termination of pregnancy.

4 2. Our AMA supports will advocate for the availability of abortion education and
5 hands-on exposure to medication and procedural abortion procedures for
6 termination of pregnancy, including medication abortions, for medical students and
7 resident/fellow physicians and opposes efforts to interfere with or restrict the
8 availability of this education and training.

9 3. In the event that medication and procedural abortion are limited or illegal in a
10 home institution, our AMA supports pathways, including cost subsidization, to
11 ensure trainees traveling to another program have hands-on training in medication
12 and procedural abortion, and will advocate for legal protections for both trainees
13 who cross state lines to receive education on reproductive health services,
14 including medication and procedural abortion, as well as the institutions facilitating
15 these opportunities.

16 34. Our AMA encourages the Accreditation Council for Graduate Medical
17 Education to consistently enforce compliance with the standardization of abortion
18 training opportunities as per the requirements set forth by the relevant Residency
19 Review Committees Review Committee for Obstetrics and Gynecology and the
20 American College of Obstetricians and Gynecologists' recommendations.; and be
21 it further

22
23 RESOLVED, That our AMA reaffirm policies H-100.948 "Supporting Access to
24 Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and
25 Reproductive Health Services."

26
27 Your Reference Committee heard live testimony on this item that indicated strong support
28 for the intent of this resolution and the need to support such medical training. Testimony
29 noted great concern regarding lack of training in certain states, given new restrictions and
30 the impact on competency, as the implications could go beyond availability of abortion
31 services. Your Reference Committee reviewed the amendments offered and gave careful
32 consideration to terminology. The Council on Medical Education offered amendments to
33 the second clause of AMA policy H-295.923 including removal of "hands-on"; your
34 Reference Committee agreed with the Council's amendments and recommended
35 replacing "hands-on" with "clinical." For the third and fourth clauses, the Council offered
36 amended language; your Reference Committee concurred and further recommended
37 adding "fellows" after "residents" in the latter part of the sentence, changing "support" to
38 "advocate" to strengthen the ask. In addition, the revised resolution calls for funding to
39 support institutions that provide this training and therefore minimize the costs to the
40 resident and sponsoring institution. Further, your Reference Committee recommended
41 that AMA Policy D-5.999, "Preserving Access to Reproductive Health Services," be
42 amended by the addition of a new clause to advocate for legal protections for medical
43 students and physicians who cross state lines to receive education in or provide
44 reproductive health services, including contraception and abortion. Therefore your
45 Reference Committee recommends that Resolution 317 be adopted as amended.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(13) RESOLUTION 307 – FAIR COMPENSATION OF
RESIDENTS AND FELLOWS

RECOMMENDATION:

**Policy H-310.912 and H-305.930 be reaffirmed in lieu of
Resolution 307.**

**HOD ACTION: Policy H-310.912 and H-305.930 reaffirmed in
lieu of Resolution 307**

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)

Your Reference Committee reviewed live and online testimony regarding this item. The author stated that teaching hospitals receive labor at well below market value. Despite significant sentiment for the spirit of the resolution, testimony reflected numerous concerns with its details. For example, the resolution's proposed increase in salaries of 50 percent could have the adverse consequence of lowering the total number of resident/fellow physician slots, with obvious negative implications for the physician workforce. Programs in smaller community hospitals could experience significant negative repercussions, due to insufficient resources and impact on meeting service needs. Other testimony noted concerns with the phrase "uniform payment" in the second resolve, in that the cost of living varies significantly based on geographic location. In response to concerns, the author proposed an amendment to the item, which, serendipitously, is nearly the same as existing Policy H-305.930. Accordingly, your Reference Committee urges reaffirmation of this policy, as well as H-310.912, in lieu of Resolution 307.

Policy recommended for reaffirmation:**H-310.912, "Residents and Fellows' Bill of Rights"**

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting

- 1 agencies within 30 days of the request; c) adequate compensation with
2 consideration to local cost-of-living factors and years of training, and to include
3 the orientation period; d) health insurance benefits to include dental and vision
4 services; e) paid leave for all purposes (family, educational, vacation, sick) to be
5 no less than six weeks per year; and f) stronger due process guidelines.
6
- 7 2. Our AMA encourages the ACGME to ensure access to educational programs
8 and curricula as necessary to facilitate a deeper understanding by resident
9 physicians of the US health care system and to increase their communication
10 skills.
11
- 12 3. Our AMA regularly communicates to residency and fellowship programs and
13 other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
14
- 15 4. Our AMA: a) will promote residency and fellowship training programs to
16 evaluate their own institution's process for repayment and develop a leaner
17 approach. This includes disbursement of funds by direct deposit as opposed to
18 a paper check and an online system of applying for funds; b) encourages a
19 system of expedited repayment for purchases of \$200 or less (or an equivalent
20 institutional threshold), for example through payment directly from their residency
21 and fellowship programs (in contrast to following traditional workflow for
22 reimbursement); and c) encourages training programs to develop a budget and
23 strategy for planned expenses versus unplanned expenses, where planned
24 expenses should be estimated using historical data, and should include trainee
25 reimbursements for items such as educational materials, attendance at
26 conferences, and entertaining applicants. Payment in advance or within one
27 month of document submission is strongly recommended.
28
- 29 5. Our AMA will partner with ACGME and other relevant stakeholders to
30 encourage training programs to reduce financial burdens on residents and
31 fellows by providing employee benefits including, but not limited to, on-call meal
32 allowances, transportation support, relocation stipends, and childcare services.
33
- 34 6. Our AMA will work with the Accreditation Council for Graduate Medical
35 Education (ACGME) and other relevant stakeholders to amend the ACGME
36 Common Program Requirements to allow flexibility in the specialty-specific
37 ACGME program requirements enabling specialties to require salary
38 reimbursement or "protected time" for resident and fellow education by "core
39 faculty," program directors, and assistant/associate program directors.
40
- 41 7. Our AMA encourages teaching institutions to offer retirement plan options,
42 retirement plan matching, financial advising and personal finance education.
43
- 44 8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as
45 applicable to all resident and fellow physicians in ACGME-accredited training
46 programs:

1 RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

2
3 Residents and fellows have a right to:

4 A. An education that fosters professional development, takes priority over
5 service, and leads to independent practice.

6 With regard to education, residents and fellows should expect: (1) A graduate
7 medical education experience that facilitates their professional and ethical
8 development, to include regularly scheduled didactics for which they are
9 released from clinical duties. Service obligations should not interfere with
10 educational opportunities and clinical education should be given priority over
11 service obligations; (2) Faculty who devote sufficient time to the educational
12 program to fulfill their teaching and supervisory responsibilities; (3) Adequate
13 clerical and clinical support services that minimize the extraneous, time-
14 consuming work that draws attention from patient care issues and offers no
15 educational value; (4) 24-hour per day access to information resources to
16 educate themselves further about appropriate patient care; and (5) Resources
17 that will allow them to pursue scholarly activities to include financial support and
18 education leave to attend professional meetings.

19 B. Appropriate supervision by qualified physician faculty with progressive
20 resident responsibility toward independent practice.

21 With regard to supervision, residents and fellows must be ultimately supervised
22 by physicians who are adequately qualified and allow them to assume
23 progressive responsibility appropriate to their level of education, competence,
24 and experience. In instances where clinical education is provided by non-
25 physicians, there must be an identified physician supervisor providing indirect
26 supervision, along with mechanisms for reporting inappropriate, non-physician
27 supervision to the training program, sponsoring institution or ACGME as
28 appropriate.

29 C. Regular and timely feedback and evaluation based on valid assessments of
30 resident performance.

31 With regard to evaluation and assessment processes, residents and fellows
32 should expect: (1) Timely and substantive evaluations during each rotation in
33 which their competence is objectively assessed by faculty who have directly
34 supervised their work; (2) To evaluate the faculty and the program confidentially
35 and in writing at least once annually and expect that the training program will
36 address deficiencies revealed by these evaluations in a timely fashion; (3)
37 Access to their training file and to be made aware of the contents of their file on
38 an annual basis; and (4) Training programs to complete primary
39 verification/credentialing forms and recredentialing forms, apply all required
40 signatures to the forms, and then have the forms permanently secured in their
41 educational files at the completion of training or a period of training and, when
42 requested by any organization involved in credentialing process, ensure the
43 submission of those documents to the requesting organization within thirty days
44 of the request.

45 D. A safe and supportive workplace with appropriate facilities.

46 With regard to the workplace, residents and fellows should have access to: (1)
47 A safe workplace that enables them to fulfill their clinical duties and educational
48 obligations; (2) Secure, clean, and comfortable on-call rooms and parking

1 facilities which are secure and well-lit; (3) Opportunities to participate on
2 committees whose actions may affect their education, patient care, workplace,
3 or contract.

4 E. Adequate compensation and benefits that provide for resident well-being and
5 health.

6 (1) With regard to contracts, residents and fellows should receive: a. Information
7 about the interviewing residency or fellowship program including a copy of the
8 currently used contract clearly outlining the conditions for (re)appointment,
9 details of remuneration, specific responsibilities including call obligations, and a
10 detailed protocol for handling any grievance; and b. At least four months advance
11 notice of contract non-renewal and the reason for non-renewal.

12 (2) With regard to compensation, residents and fellows should receive: a.
13 Compensation for time at orientation; and b. Salaries commensurate with their
14 level of training and experience. Compensation should reflect cost of living
15 differences based on local economic factors, such as housing, transportation,
16 and energy costs (which affect the purchasing power of wages), and include
17 appropriate adjustments for changes in the cost of living.

18 (3) With regard to benefits, residents and fellows must be fully informed of and
19 should receive: a. Quality and affordable comprehensive medical, mental health,
20 dental, and vision care for residents and their families, as well as retirement plan
21 options, professional liability insurance and disability insurance to all residents
22 for disabilities resulting from activities that are part of the educational program;
23 b. An institutional written policy on and education in the signs of excessive
24 fatigue, clinical depression, substance abuse and dependence, and other
25 physician impairment issues; c. Confidential access to mental health and
26 substance abuse services; d. A guaranteed, predetermined amount of paid
27 vacation leave, sick leave, family and medical leave and
28 educational/professional leave during each year in their training program, the
29 total amount of which should not be less than six weeks; e. Leave in compliance
30 with the Family and Medical Leave Act; and f. The conditions under which
31 sleeping quarters, meals and laundry or their equivalent are to be provided.

32 F. Clinical and educational work hours that protect patient safety and facilitate
33 resident well-being and education.

34 With regard to clinical and educational work hours, residents and fellows should
35 experience: (1) A reasonable work schedule that is in compliance with clinical
36 and educational work hour requirements set forth by the ACGME; and (2) At-
37 home call that is not so frequent or demanding such that rest periods are
38 significantly diminished or that clinical and educational work hour requirements
39 are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow
40 Clinical and Educational Work Hours," for more information.

41 G. Due process in cases of allegations of misconduct or poor performance.

42 With regard to the complaints and appeals process, residents and fellows should
43 have the opportunity to defend themselves against any allegations presented
44 against them by a patient, health professional, or training program in accordance
45 with the due process guidelines established by the AMA.

46 H. Access to and protection by institutional and accreditation authorities when
47 reporting violations.

1 With regard to reporting violations to the ACGME, residents and fellows should:
2 (1) Be informed by their program at the beginning of their training and again at
3 each semi-annual review of the resources and processes available within the
4 residency program for addressing resident concerns or complaints, including the
5 program director, Residency Training Committee, and the designated
6 institutional official; (2) Be able to file a formal complaint with the ACGME to
7 address program violations of residency training requirements without fear of
8 recrimination and with the guarantee of due process; and (3) Have the
9 opportunity to address their concerns about the training program through
10 confidential channels, including the ACGME concern process and/or the annual
11 ACGME Resident Survey.
12

13 9. Our AMA will work with the ACGME and other relevant stakeholders to
14 advocate for ways to defray additional costs related to residency and fellowship
15 training, including essential amenities and/or high cost specialty-specific
16 equipment required to perform clinical duties.
17

18 10. Our AMA believes that healthcare trainee salary, benefits, and overall
19 compensation should, at minimum, reflect length of pre-training education, hours
20 worked, and level of independence and complexity of care allowed by an
21 individual's training program (for example when comparing physicians in training
22 and midlevel providers at equal postgraduate training levels).
23

24 11. The Residents and Fellows' Bill of Rights will be prominently published online
25 on the AMA website and disseminated to residency and fellowship programs.
26

27 12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights
28 online and individually to residency and fellowship training programs and
29 encourage changes to institutional processes that embody these principles.
30

31 **H-305.930, "Residents' Salaries"**
32

33 Our AMA supports appropriate increases in resident salaries.

RECOMMENDED FOR ADOPTION IN LIEU OF

- 1
2
3 (14) RESOLUTION 311 – SUPPORTING A HYBRID
4 RESIDENCY AND FELLOWSHIP INTERVIEW PROCESS
5

RECOMMENDATION:

6
7
8 **Alternate Resolution 311 be adopted in lieu of**
9 **Resolution 311, to read as follows:**

**SUPPORT HYBRID INTERVIEW TECHNIQUES FOR
ENTRY TO GRADUATE MEDICAL EDUCATION**

10
11
12
13
14 **RESOLVED, That our AMA work with relevant**
15 **stakeholders to study the advantages and**
16 **disadvantages of an online medical school interview**
17 **option for future medical school applicants, including**
18 **but not limited to financial implications and potential**
19 **solutions, long term success, and well-being of**
20 **students and residents (New HOD Policy); and be it**
21 **further**

22
23 **RESOLVED, That our AMA encourage appropriate**
24 **stakeholders, such as the Association of American**
25 **Medical Colleges, American Association of Colleges of**
26 **Osteopathic Medicine, Intealth, and Accreditation**
27 **Council for Graduate Medical Education, to study the**
28 **feasibility and utility of videoconferencing for graduate**
29 **medical education (GME) interviews and examine**
30 **interviewee and program perspectives on incorporating**
31 **videoconferencing as an adjunct to GME interviews, in**
32 **order to guide the development of equitable protocols**
33 **for expansion of hybrid GME interviews (Directive to**
34 **Take Action).**

35
36 **HOD ACTION: Alternate Resolution 311 adopted in lieu of**
37 **Resolution 311**

38
39 RESOLVED, That our American Medical Association support incorporating virtual
40 interviews as a component to the residency and fellowship interview process as a means
41 to increase interviewing efficiency (New HOD Policy); and be it further
42

43 RESOLVED, That our AMA work with appropriate stakeholders, such as the Association
44 of American Medical Colleges and the Accreditation Council for Graduate Medical
45 Education, to study interviewee and program perspectives on incorporating
46 videoconferencing as an adjunct to residency and fellowship interviews, in order to guide
47 the development of protocols for expansion of hybrid residency and fellowship interviews.
48 (Directive to Take Action)

1 Your Reference Committee reviewed live and online testimony regarding this item.
2 Testimony was supportive of the second resolve seeking study. Testimony also favored
3 study of the first resolve, noting that data derived from the study of interviewee and
4 program perspectives, per the second resolve, could help to inform how to best address
5 the first resolve. The Council on Medical Education supported study of both resolves
6 and recommended amendments, offering substitute language for the first resolve to
7 study the advantages and disadvantages of an online medical school interview option
8 for future medical school applicants, and amending the second resolve with clarifying
9 language. The author of the resolution supported the Council's recommendations. In the
10 second resolve, testimony recommended adding the American Association of Colleges
11 of Osteopathic Medicine and InTealth (the parent organization of the Educational
12 Commission for Foreign Medical Graduates) to the relevant stakeholders. Your
13 Reference Committee recommended retitling the resolution for clarity, as the current
14 wording could be misconstrued as a joint process for entry to residency and fellowship.
15 Therefore, your Reference Committee recommends that Resolution 311 be adopted as
16 amended.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee F

Cheryl Gibson Fountain, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2
3 **RECOMMENDED FOR ADOPTION**

- 4
5 1. Board of Trustees Report 7 - Transparency of Resolution Fiscal Notes
6
7 2. Speakers' Report 1 - Election Committee-Interim Report
8
9 3. Report of the House of Delegates Committee on the Compensation of the
10 Officers
11
12 4. Council on Long Range Planning and Development Report 1 - Senior Physicians
13 Section Five-Year Review
14

15 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 16
17 5. Board of Trustees Report 2 - Further Action to Respond to the Gun Violence
18 Public Health Crisis
19

20 **RECOMMENDED FOR REFERRAL**

- 21
22 6. Board of Trustees Report 9 - Employed Physicians
23
24 7. Resolution 602 - Finding Cities for Future AMA Conventions/Meetings
25
26 8. Resolution 607 - Accountability for Election Rules Violations
27

28 **RECOMMENDED FOR REFERRAL FOR DECISION**

- 29
30 9. Resolution 609 - AMA Declares its Support for Turkish Physicians Imprisoned in
31 Turkey in Violation of their Human and Professional Rights
32

33 **RECOMMENDED FOR NOT ADOPTION**

- 34
35 10. Board of Trustees Report 8 - The Resolution Committee as a Standing
36 Committee of the House
37
38 11. Resolution 601 - AMA Withdraw its Organizational Strategic Plan to Embed
39 Racial Justice and Advance Health Equity

- 1 12. Resolution 606 - Patient-Centered Health Equity Strategic Plan and Sustainable
- 2 Funding

Amendments

If you wish to propose an amendment to an item of business, click here:

[Submit New Amendment](#)

RECOMMENDED FOR ADOPTION

- 1
2 (1) BOARD OF TRUSTEES REPORT 7 - TRANSPARENCY
3 OF RESOLUTION FISCAL NOTES
4

5 **RECOMMENDATION:**
6

7 **Recommendation in Board of Trustees Report 7 be**
8 **adopted, and the remainder of the Report be filed.**
9

10 **HOD ACTION: Recommendation in Board of Trustees**
11 **Report 7 adopted and the remainder of the Report filed**
12

13 Your Board of Trustees recommends that Resolution 608 not be adopted, and the
14 remainder of the report be filed.
15

16 One individual commented on the online forum in opposition to the Board report and
17 proposed that AMA policy G-600.061 be amended to exclude from fiscal notes resolutions
18 that contain only advocacy statements, albeit advocacy has fiscal implications.
19

20 Your Reference Committee extends its appreciation to the Board of Trustees for providing
21 comprehensive details regarding the development of fiscal notes and recommends that
22 Board of Trustees Report 7 be adopted.
23

- 24
25 (2) SPEAKERS' REPORT 1 - ELECTION COMMITTEE –
26 INTERIM REPORT
27

28 **RECOMMENDATION:**
29

30 **Recommendations in Speakers' Report 1 be adopted**
31 **and the remainder of the Report be filed.**
32

33 **HOD ACTION: Recommendations in Speakers' Report 1**
34 **adopted and the remainder of the Report filed**
35

36 It is recommended that the following recommendations be adopted, and the remainder of
37 the report filed.
38

- 39 1. That Policy D-610.998, Paragraph 5, be amended by addition and deletion to read as
40 follows:
41

42 In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of
43 7-9 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime
44 maximum tenure of 8 terms) to report to the Speaker. These individuals would agree
45 not to be directly involved in a campaign during their tenure and would be appointed
46 from various regions, specialties, sections, and interest groups. The primary role of
47 the committee would be to work with the Speakers to adjudicate any election
48 complaint. Additional roles to be determined by the Speaker and could include

1 monitoring election reforms, considering future campaign modifications and
2 responding to requests from the Speaker for input on election issues that arise. The
3 Speaker and Vice Speaker shall be full members of the Election Committee. (Modify
4 Current HOD Policy)

- 5
6 2. That Policy D-610.998, Paragraph 7, be amended by addition to read as follows:

7
8 Campaign violation complaints will be investigated by the Election Committee or a
9 subcommittee thereof with the option of including the Office of General Counsel or the
10 Director of the House of Delegates. (Modify Current HOD Policy)

- 11
12 3. That Policy D-610.998, Paragraph 7(a), be amended by addition to read as follows:

13
14 7(a). The Committee will collectively determine whether a campaign violation has
15 occurred. As part of the investigation process the Election Committee or its
16 subcommittee shall inform the candidate of the complaint filed and give the
17 candidate the opportunity to respond to the allegation. (Modify Current HOD
18 Policy)

- 19
20 4. That Paragraph 7 be amended by addition of a new sub point “b” to read as follows:

21
22 7(b) If the complaint implicates a delegation or caucus, the Election Committee or its
23 subcommittee shall inform the chair of the implicated delegation or caucus of the
24 complaint filed and give the implicated delegation or caucus chair(s) the
25 opportunity to answer to the allegation as a part of the investigative process.
26 (Modify Current HOD Policy)

- 27
28 5. That amended Policy D-610.998 be widely communicated, including being published
29 in the Election Manual. (Directive to Take Action)

30
31 Testimony was supportive of the report recommendations, which offered language to
32 further clarify and codify the processes followed by the Election Committee. Testimony
33 noted the importance of ensuring due process and minimizing conflicts.

34
35 One amendment called for individuals appointed to the election committee to agree to not
36 run for an AMA elected position for at least one year after completing their service on the
37 committee. Your Reference Committee was concerned that this amendment may pose
38 unintended consequences related to the role of the Speaker and Vice Speaker, and
39 believes this will be addressed in the planned report from the Election Task Force which
40 is anticipated next year.

41
42 Your Reference Committee recommends that Speakers’ Report 1 be adopted.

1 (3) REPORT OF THE HOUSE OF DELEGATES COMMITTEE
2 ON THE COMPENSATION OF THE OFFICERS
3

4 **RECOMMENDATION:**
5

6 **Recommendations in Report of the House of Delegates**
7 **Committee on the Compensation of the Officers be**
8 **adopted and the remainder of the Report be filed.**
9

10 **HOD ACTION: Recommendations in Report of the House of**
11 **Delegates Committee on the Compensation of the Officers**
12 **adopted and the remainder of the Report filed**
13

- 14 1. That there be no changes to the Officers' compensation for the period beginning
15 July 1, 2022 through June 30, 2023. (Directive to Take Action.)
16
17 2. That the remainder of the report be filed.
18

19 One individual commented that it has been at least 25 years since the \$750 per year that
20 is allocated for secretarial support was adjusted. No other comments were received.
21

22 Your Reference Committee noted the report reflects the annual limit for secretarial support
23 during the Presidential year is \$15,000, and \$5,000 each for the President-Elect, Chair,
24 Chair-Elect, and Immediate Past President. Secretarial expenses incurred by other
25 Officers is \$750 annually and is in addition to administrative support provided by the AMA's
26 Board office.
27
28

29 (4) COUNCIL ON LONG RANGE PLANNING AND
30 DEVELOPMENT REPORT 1 - SENIOR PHYSICIANS
31 SECTION FIVE-YEAR REVIEW
32

33 **RECOMMENDATION:**
34

35 **Recommendation in Council on Long Range Planning**
36 **and Development Report 1 be adopted and the**
37 **remainder of the Report be filed.**
38

39 **HOD ACTION: Recommendation in Council on Long Range**
40 **Planning and Development Report 1 adopted and the**
41 **remainder of the Report filed**
42

43 The Council on Long Range Planning and Development recommends that our American
44 Medical Association renew delineated section status for the Senior Physicians Section
45 through 2027 with the next review no later than the 2027 Interim Meeting and that the
46 remainder of this report be filed. (Directive to Take Action)
47

48 In addition to the author's introduction of the report, your Reference Committee received
49 testimony from the Senior Physicians Section emphasizing the importance of

- 1 incorporating demographic changes into the representation of the House of Delegates,
- 2 and thanked the Council for their thoughtful work.
- 3
- 4 Your Reference Committee recommends that the recommendations in the Council on
- 5 Long Range Planning and Development Report be adopted, and the remainder be filed.

RECOMMENDED FOR ADOPTION AS AMENDED

- 1
2 (5) BOARD OF TRUSTEES REPORT 2 - FURTHER ACTION
3 TO RESPOND TO THE GUN VIOLENCE PUBLIC
4 HEALTH CRISIS

RECOMMENDATION A:

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

10
11 The Board of Trustees recommends that the following be
12 adopted in lieu of Resolution 246-A-22 and that the
13 remainder of the report be filed:

14
15 1. Our AMA will make readily accessible on the AMA
16 website the comprehensive summary of AMA policies,
17 plans, current activities, and progress regarding the public
18 health crisis of firearm violence. (New HOD Policy)

19
20 2. Our AMA will establish a task force to focus on gun
21 violence prevention including gun-involved suicide.
22 (Directive to Take Action)

23
24 3. Our AMA will support and consider providing grants to
25 evidence-based firearm violence interruption programs in
26 communities, schools, hospitals, and clinics. (Directive to
27 Take Action)

28
29 4. Our AMA will collaborate with interested state and
30 specialty societies to increase engagement in litigation
31 related to firearm safety. (Directive to Take Action)

32
33 5. Our AMA will report annually to the House of Delegates
34 on our AMA's efforts relating to legislation, regulation, and
35 litigation at the federal, state, and local levels to prevent gun
36 violence. (Directive to Take Action)

RECOMMENDATION B:

37
38
39
40 **Recommendation in Board of Trustees Report 2 be**
41 **adopted as amended** and the remainder of the Report
42 **be filed.**

43
44 **HOD ACTION: Recommendation in Board of Trustees**
45 **Report 2 adopted as amended and the remainder of the**
46 **Report filed**

1 The Board of Trustees recommends that the following be adopted in lieu of Resolution
2 246 and that the remainder of the report be filed:

3
4 Our AMA will make readily accessible on the AMA website the comprehensive summary
5 of AMA policies, plans, current activities, and progress regarding the public health crisis
6 of firearm violence. (New HOD Policy)

7
8 Despite testimony from the Board of Trustees emphasizing the current work of the Board
9 towards mitigating gun violence and explaining potential unintended consequences of
10 forming an official task force, there was overwhelming testimony in support of the creation
11 and implementation of a task force on the topic of gun violence. Testimony posits that a
12 task force will demonstrate a commitment to the public in addition to putting the AMA in a
13 position to be a leader among other organizations. Testimony indicated that while current
14 AMA efforts reflect a good start, it is simply not enough to mitigate gun violence. Testimony
15 stressed that not only does gun violence impact patients' lives, health, and mental well-
16 being, but also, it impacts physician safety through mass shooting events at healthcare
17 facilities. Moreover, a task force could enhance the Board of Trustees current efforts to
18 put an end to gun violence in this country.

19
20 Your Reference Committee recommends that the report be adopted as amended.

RECOMMENDED FOR REFERRAL

1
2 (6) BOARD OF TRUSTEES REPORT 9 - EMPLOYED
3 PHYSICIANS

4
5 **RECOMMENDATION:**

6
7 **Board of Trustees Report 9 be referred.**

8
9 **HOD ACTION: Board of Trustees Report 9 referred**

10
11 Your Board of Trustees recommends that the following recommendations be adopted in
12 lieu of Resolution 615-N-21, and that the remainder of this report be filed:

13
14 1. That our AMA adopt the following definition of “employed physician”:

15
16 An employed physician is any non-resident, non-fellow physician who maintains a
17 contractual relationship to provide medical services with an entity from which the
18 physician receives a W-2 to report their income, and in which the physician does not
19 have a controlling interest, either individually or as part of a collective. (New HOD
20 Policy)

21
22 2. That our AMA re-examine the representation of employed physicians within the
23 organization and report back at the 2024 Annual Meeting. (Directive to Take Action)

24
25 Testimony described the definition of employed physician in the report as being
26 inadequate to properly encompass its complexity. Some testimony expressed concerns
27 about the timeline presented in the report. It was suggested to move up the time for a
28 report back sooner than the 2024 Annual Meeting. Your reference committee
29 recommends that the report back be moved up to the Interim 2023 meeting.

30
31 Due to differing ideas for amendments, and the complexity in defining “employed
32 physician,” your Reference Committee recommends that the Board of Trustees Report be
33 referred to gain a better understanding and thus propose more impactful solutions.

34
35
36 (7) RESOLUTION 602 - FINDING CITIES FOR FUTURE AMA
37 CONVENTIONS/MEETINGS

38
39 **RECOMMENDATION:**

40
41 **Resolution 602 be referred.**

42
43 **HOD ACTION: Resolution 602 referred**

44
45 RESOLVED, That our American Medical Association amend Policy G-630.140, “Lodging,
46 Meeting Venues, and Social Functions,” by addition and deletion to read as follows:

47
48 AMA policy on lodging and accommodations includes the following:

- 1
- 2 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions
- 3 based on size, service, location, cost, and similar factors.
- 4 2. Our AMA shall attempt, when allocating meeting space, to locate the Section
- 5 Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close
- 6 proximity.
- 7
- 8 3. All meetings and conferences organized and/or primarily sponsored by our AMA
- 9 will be held in a town, city, county, or state that has regulation or enacted
- 10 ~~comprehensive~~ legislation requiring smoke-free worksites and public places
- 11 (including restaurants and bars), unless intended or existing contracts or special
- 12 circumstances justify an exception to this policy, and our AMA encourages state
- 13 and local medical societies, national medical specialty societies, and other health
- 14 organizations to adopt a similar policy.
- 15
- 16 4. It is the policy of our AMA not to ~~hold meetings organized and/or primarily~~
- 17 ~~sponsored by our AMA, in cities, counties, or states,~~ or pay member, officer or
- 18 employee dues in any club, restaurant, or other institution, that has exclusionary
- 19 policies, including, but not limited to, policies based on, race, color, religion,
- 20 national origin, ethnic origin, language, creed, sex, sexual orientation, gender,
- 21 gender identity and gender expression, disability, or age unless intended or
- 22 existing contracts or special circumstances justify an exception to this policy.
- 23
- 24 5. Our AMA staff will work with facilities where AMA meetings are held to designate
- 25 an area for breastfeeding and breast pumping.
- 26
- 27 6. All future AMA meetings will be structured to provide accommodations for
- 28 members and invited attendees who are able to physically attend, but who need
- 29 assistance in order to meaningfully participate.
- 30
- 31 7. Our AMA will revisit our criteria for selection of hotels and other venues in order to
- 32 facilitate maximum participation by members and invited attendees with
- 33 disabilities.
- 34
- 35 8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting
- 36 with a plan on how to maximize meeting participation for members and invited
- 37 attendees with disabilities. (Modify Current HOD Policy)
- 38

39 Your Reference Committee, as well as those who testified, acknowledge that the selection
40 of future AMA meeting venues is a complex matter due to several AMA policies that restrict
41 venue selection. Additionally, there are a limited number of venues that can accommodate
42 the increasing size of our AMA House of Delegates and its sections without requiring
43 multiple hotels and/or a convention center.

44
45 Your Reference Committee believes, and testimony supports, referral of this resolution to
46 allow our AMA Board of Trustees and its management team the opportunity to address
47 any immediate decisions and to provide our House of Delegates with a report back at the
48 2023 Interim Meeting that outlines options for the future, including but not limited to options
49 for expanding potential venue choices, recommendations for possible policy changes, and
50 the political ramifications of boycotting specific states.

1 (8) RESOLUTION 607 - ACCOUNTABILITY FOR ELECTION
2 RULES VIOLATIONS

3
4 **RECOMMENDATION:**

5
6 **Resolution 607 be referred.**

7
8 **HOD ACTION: Resolution 607 referred**

9
10 RESOLVED, That our American Medical Association empower the Election Committee to
11 develop a list of appropriate penalties for candidates and caucus/delegation/section
12 leadership who violate election rules (Directive to Take Action); and be it further

13
14 RESOLVED, That the Election Committee define potential election rule violations as minor
15 (oversight or misinterpretation of rules), moderate (more serious and more likely to affect
16 the outcome of an election), and severe (intentional violation with high likelihood of
17 affecting the outcome of an election) and assign appropriate penalties or actions to
18 remedy the situation and/or report the violation to the House of Delegates (Directive to
19 Take Action); and be it further

20
21 RESOLVED, That any candidate who is deemed to have violated the vote trading election
22 rule be disqualified from the current race as well as any future races at the AMA for a
23 period not less than 2 years, upon the recommendation of the Election Committee and
24 approval of the full House of Delegates (Directive to Take Action); and be it further

25
26 RESOLVED, That any caucus/delegation/section leadership that is found to have
27 engaged in vote trading shall not be allowed to sponsor any candidates for a period not
28 less than 2 years (Directive to Take Action); and be it further

29
30 RESOLVED, That anyone who is deemed by the Election Committee to have knowingly
31 and egregiously violated the vote trading rule be referred to the Council on Ethical and
32 Judicial Affairs for potential ethics violations. (Directive to Take Action)

33
34 Testimony was generally supportive of identifying penalties for campaign violations.
35 Although testimony emphasized the importance of a fair, transparent process, and the
36 need for due process, there was dissonance on the best approach for codifying penalties.

37
38 Testimony noted concerns over the feasibility of developing all necessary disciplinary
39 actions in advance. Further, the testimony was split over the appropriate body to finalize
40 these disciplinary actions.

41
42 Your Reference Committee believes that referring Resolution 607 would allow an
43 opportunity to study this issue in an effort to develop the best approach.

RECOMMENDED FOR REFERRAL FOR DECISION

- 1
2 (9) RESOLUTION 609 - AMA DECLARES ITS SUPPORT
3 FOR TURKISH PHYSICIANS IMPRISONED IN TURKEY
4 IN VIOLATION OF THEIR HUMAN AND PROFESSIONAL
5 RIGHTS
6

7 **RECOMMENDATION:**
8

9 **Resolution 609 be referred for decision.**
10

11 **HOD ACTION: Resolution 609 referred for decision**
12

13 RESOLVED, That our American Medical Association reaffirms Resolution H-65.991,
14 "Persecution of Physicians for Political Reasons and Participation by Doctors in
15 Violations of Human Rights", and H-65.994, "Medical Care in Countries in Turmoil"
16 (Reaffirm HOD Policy); and be it further
17

18 RESOLVED, That our AMA recommends to its Delegation to the World Medical
19 Association (WMA) to offer AMA's assistance to the WMA with efforts to free unjustly
20 imprisoned health professionals and to preserve the independence of the Turkish
21 Medical Association (Directive to Take Action); and be it further
22

23 RESOLVED, That the President of the AMA will write to the U.S. Secretary of State to
24 express AMA's concerns and to ask the Secretary to intervene in support of these
25 Turkish health professionals and the independence of the Turkish Medical Association.
26 (Directive to Take Action)
27

28 Your Reference Committee received testimony highlighting the urgency of acting swiftly
29 in support of our Turkish colleagues and the Turkish Medical Association. Additional
30 testimony from our Board of Trustees indicated that referral for decision of this item would
31 allow for amplification of our AMA voice through our AMA delegation to the World Medical
32 Association. For these reasons, your Reference Committee recommends support for the
33 requested referral for decision.

RECOMMENDED FOR NOT ADOPTION

- 1
2 (10) BOARD OF TRUSTEES REPORT 8 - THE RESOLUTION
3 COMMITTEE AS A STANDING COMMITTEE OF THE
4 HOUSE
5

6 **RECOMMENDATION:**
7

8 **Recommendation in Board of Trustees Report 8 not be**
9 **adopted and the remainder of the Report be filed.**

10
11 **HOD ACTION: Recommendation in Board of Trustees**
12 **Report 8 not adopted and the remainder of the Report filed**
13

14 Your Board of Trustees offers the following recommendation to be adopted in lieu of
15 Resolutions 605-N-21 and 619-A-22 and the remainder of the report filed.
16

17 That the Board of Trustees prepare a report for consideration at the 2023 Annual Meeting
18 recommending a trial of a resolution committee, including the make-up and operation of
19 the committee and create measures of fairness and effectiveness of the trial. (Directive to
20 Take Action)
21

22 Testimony overwhelmingly opposed the recommendation to conduct a trial of a Resolution
23 Committee. Several concerns associated with a resolution committee were cited,
24 including: diminished ability for minority perspectives to be heard; potential for creating
25 another backlog of resolutions after trial completion; limited debate on topics that could
26 signal emerging problems or issues of concern; compromised adherence to the
27 democratic process; and reduced member engagement in the policy process.
28

29 In addition, testimony indicated that many time-sensitive resolutions may not have been
30 considered due to dependence on a scoring system in lieu of the Resolution Committee
31 convening to discuss their recommendations. Further, it was noted that when the HOD
32 voted on the recommendations of the Resolution Committee, none of the committee
33 decisions were overturned.
34

35 Opposing testimony noted that, in principle, a trial of a Resolution Committee occurred
36 during three of the special meetings of the House of Delegates. Further, testimony
37 supported using lessons learned from the special meetings to adopt efficient practices for
38 future meetings. It was noted, however, that the experience of the special meetings was
39 due to extenuating circumstances associated with the COVID-19 pandemic.
40

41 Testimony in support of the trial of a resolution committee noted that this could be a
42 catalyst toward making policy discussions more focused and efficient given the costs
43 associated with sending delegates to AMA meetings.
44

45 Your Reference Committee wishes to note that amendments were offered in support of
46 forming a committee to evaluate possible next steps based on lessons learned from the
47 special meetings, as well as additional aspects about the resolution process that would be
48 beneficial.

1 Although your Reference Committee acknowledges that promoting focus and efficiency
2 for policy deliberations was favored by many individuals providing testimony, there were
3 disparate opinions for the best mechanism to accomplish this goal. Given the
4 overwhelming testimony in opposition to the formation of a resolution committee, your
5 Reference Committee recommends that Board of Trustees Report 8 not be adopted.
6
7

8 (11) RESOLUTION 601 - AMA WITHDRAW ITS
9 ORGANIZATIONAL STRATEGIC PLAN TO EMBED
10 RACIAL JUSTICE AND ADVANCE HEALTH EQUITY
11

12 **RECOMMENDATION:**

13
14 **Resolution 601 not be adopted.**

15
16 **HOD ACTION: Resolution 601 not adopted**

17
18 RESOLVED, That our American Medical Association withdraw its Organizational Strategic
19 Plan to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and
20 rewrite the recommendations for correcting its past support for racially discriminating
21 behavior with removal of the inflammatory rhetoric. (Directive to Take Action)
22

23 There was a plethora of testimony in strong opposition of this resolution. This is the third
24 time the sentiment of this resolution has been brought before the House, and it has been
25 defeated two times prior. Testimony posits that while it is challenging to change the culture
26 of medicine and face individual contributions toward perpetuating systems of oppression,
27 it is necessary to move forward and advance health equity. Testimony was
28 overwhelmingly supportive of the Center for Health Equity and the strategic plan to embed
29 racial justice and health equity. According to testimony, this amendment would take the
30 AMA backwards, instead of propelling it forward.
31

32 Based on abundant testimony in strong opposition, your Reference Committee
33 recommends that resolution 601 not be adopted.
34
35

36 (12) RESOLUTION 606 - PATIENT-CENTERED HEALTH
37 EQUITY STRATEGIC PLAN AND SUSTAINABLE
38 FUNDING
39

40 **RECOMMENDATION:**

41
42 **Resolution 606 not be adopted.**

43
44 **HOD ACTION: Resolution 606 not adopted**

45
46 RESOLVED, Our American Medical Association HOD reaffirm policy H-180.944, "Plan for
47 Continued Progress Toward Health Equity," and aggressively advocate for Health Equity
48 as defined as optimal health for all which should be the goal toward which our AMA will
49 work by advocating for health care access, promoting equity in care, increasing health

1 workforce diversity, influencing determinants of health, and voicing and modeling
2 commitment to health equity (Reaffirm HOD Policy); and be it further

3
4 RESOLVED, That our AMA Center for Health Equity's future strategic plan should include
5 advocacy planning and be presented to the AMA HOD for consideration with the
6 opportunity for it to be more widely understood, strengthened, and supported by the HOD
7 (Directive to Take Action); and be it further

8
9 RESOLVED, As the AMA Center for Health Equity develops its next strategic plan, it shall
10 actively engage our AMA Board of Trustees in the strategic planning process, and ensure
11 a more patient-centered strategic plan for health equity advocacy that is consistent with
12 the intent of AMA policies, including H-180.944, "Plan for Continued Progress Toward
13 Health Equity," and D-180.981, "Plan for Continued Progress Toward Health Equity," and
14 report the strategic plan to the HOD at the 2024 Annual Meeting prior to publicly releasing
15 the plan to the press (Directive to Take Action); and be it further

16
17 RESOLVED, That our AMA, in a collaboration with interested stakeholders, actively
18 advocate for sustainable funding from Congress to increase health equity efforts of
19 identifying and reducing health disparities including but not limited to funding of the Health
20 Resources and Services Administration through U.S. Department of Health and Human
21 Services and our AMA Health Equity Center. (Directive to Take Action)

22
23 Your Reference committee heard testimony in strong opposition to this resolution.
24 Testimony noted that no other department of the AMA is subjected to presenting and
25 obtaining approval of their strategic plan by the House of Delegates. Moreover, this
26 resolution would add another layer of obstacles and impede the important work of the
27 Center for Health Equity.

28
29 While there was no testimony in opposition to the first and fourth clauses, the sentiments
30 of these clauses are already present in existing policy. Therefore, your Reference
31 Committee recommends that resolution 606 be not adopted.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee J

Brigitta J. Robinson, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

**2
3 RECOMMENDED FOR ADOPTION**

- 4
5 1. CMS Report 01 – Incentives to Encourage the Efficient Use of Emergency
6 Departments
7 2. Resolution 805 – COVID Vaccine Administration Fee
8 3. Resolution 820 – Third-Party Pharmacy Benefit Administrators
9

10 RECOMMENDED FOR ADOPTION AS AMENDED

- 11
12 4. CMS Report 02 – Corporate Practice of Medicine
13 5. Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for
14 All Service Members and Veterans
15 6. Resolution 802 – FAIR Health Database
16 7. Resolution 809 – Uniformity and Enforcement of Medicare Advantage Plans and
17 Regulations
18 8. Resolution 811 – Covering Vaccinations for Seniors through Medicare Part B
19 9. Resolution 812 – Implant-Associated Anaplastic Large Cell Lymphoma
20 10. Resolution 816 – Medicaid and CHIP Coverage for Glucose Monitoring Devices
21 for Patients with Diabetes
22 11. Resolution 821 – PrEP is an Essential Health Benefit
23 12. Resolution 826 – Leveling the Playing Field
24

25 RECOMMENDED FOR ADOPTION IN LIEU OF

- 26
27 13. Resolution 806 – Healthcare Marketplace Plan Selection
28 14. Resolution 813 – Amending Policy on a Public Option to Maximize AMA
29 Advocacy
30 15. Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or
31 Ignored?
32 16. Resolution 815 – Opposition to Debt Litigation Against Patients
33 17. Resolution 817 – Promoting Oral Anticancer Drug Parity
34 18. Resolution 818 – Pediatric Obesity Treatment Insurance Coverage

- 1 19. Resolution 819 – Advocating for the Implementation of Updated U.S. Preventive
2 Services Task Force Recommendations for Colorectal Cancer Screening Among
3 Primary Care Physicians and Major Payors by the AMA
4

5 **RECOMMENDED FOR REFERRAL**
6

- 7 20. Resolution 823 – Health Insurers and Collection of Co-Pays and Deductibles
8 21. Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care
9 When Physicians Deliver Care Across Diverse Problem Sets
10

11 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**
12

- 13 22. Resolution 804 – Centers for Medicare & Medicaid Innovation Projects
14 23. Resolution 808 – Reinstatement of Consultation Codes
15 24. Resolution 810 – Medicare Drug Pricing and Pharmacy Costs
16 25. Resolution 822 – Monitoring of Alternative Payment Models within Traditional
17 Medicare
18

RECOMMENDED FOR ADOPTION

(1) CMS REPORT 01 - INCENTIVES TO ENCOURAGE
EFFICIENT USE OF EMERGENCY DEPARTMENTS

RECOMMENDATION:

CMS Report 1 be adopted and the remainder of the report
be filed.

**HOD ACTION: CMS Report 1 adopted and the remainder of
the report filed**

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

1. That our American Medical Association (AMA) 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 that 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)

Testimony was overwhelmingly supportive of CMS Report 01. There was an amendment proposed by the Medical Student Section (MSS) to address co-pays and other cost-sharing measures for Medicaid patients receiving care in the Emergency Department. The Council on Medical Service commented that the MSS amendment goes beyond the

1 purview of this report. Your Reference Committee agrees. Therefore, your Reference
2 Committee thanks the Council on Medical Service for a well-written report and
3 recommends the report be adopted the remainder of the report be filed.

4
5 (2) RESOLUTION 805 - COVID VACCINE ADMINISTRATION
6 FEE

7
8 RECOMMENDATION:

9
10 Resolution 805 be adopted.

11
12 **HOD ACTION: Resolution 805 adopted**

13
14 RESOLVED, That American Medical Association Policy D-440.981, "Appropriate
15 Reimbursements and Carve-outs for Vaccines," be amended by addition to read as
16 follows:

17
18 **Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

19 Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services
20 (CMS) and provide comment on the Medicare Program payment policy for vaccine
21 services; (2) continue to pursue adequate reimbursement for vaccines and their
22 administration from all public and private payers, including federal funds to reimburse for
23 administration of the COVID-19 vaccine to uninsured patients; (3) encourage health
24 plans to recognize that physicians incur costs associated with the procurement, storage
25 and administration of vaccines that may be beyond the average wholesale price of any
26 one particular vaccine; (4) seek legislation mandating that health insurance companies
27 in applicable states either adequately pay for vaccines recommended by the Advisory
28 Committee on Immunization Practices, or clearly state in large bold font in their notices
29 to patients and businesses that they do not follow the federal advisory body on vaccine
30 recommendations, the Advisory Committee on Immunization Practices; and (5) advocate
31 that a physician's office can bill Medicare for all vaccines administered to Medicare
32 beneficiaries and that the patient shall only pay the applicable copay to prevent
33 fragmentation of care. (Modify Current HOD Policy)

34
35 Your Reference Committee heard mostly supportive testimony for Resolution 805.
36 Contrary testimony from the Council on Medical Service called for reaffirmation of
37 existing policy. Your Reference Committee did not find this compelling. The topic of
38 vaccine reimbursement is important policy should be strengthened to specifically call out
39 including federal funds to reimburse for the administration of the COVID-19 vaccine to
40 uninsured patients. Several state and specialty delegations spoke in favor of adopting
41 this resolution. Your Reference Committee recommends Resolution 805 be adopted.

42
43 (3) RESOLUTION 820 - THIRD-PARTY PHARMACY
44 BENEFIT ADMINISTRATORS

45
46 RECOMMENDATION:

47
48 Resolution 820 be adopted.

49
50 **HOD ACTION: Resolution 820 adopted**

1 RESOLVED, That our American Medical Association recommend that third-party
2 pharmacy benefit administrators that contract to manage the specialty pharmacy portion
3 of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory
4 frameworks and statutes, and be subject to the same licensing, registration, and
5 transparency reporting requirements (New HOD Policy); and be it further
6 RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be
7 included in future PBM oversight efforts at the state and federal levels. (Directive to Take
8 Action)

9
10 Testimony was unanimously supportive of Resolution 820 as written. Speakers raised
11 the importance of the expansion of existing regulations covering PBMs to cover third-
12 party pharmacy benefit administrators. Testimony explained that many PBMs utilize the
13 lack of regulation of third-party benefit administrators as a loophole to skirt existing
14 regulations. A number of specialty societies outlined the negative impact that these
15 actions have on patients and their access to necessary medications. Therefore, your
16 Reference Committee recommends that Resolution 820 be adopted.
17

RECOMMENDED FOR ADOPTION AS AMENDED**(4) CMS REPORT 02 - CORPORATE PRACTICE OF MEDICINE****RECOMMENDATION A:**

Recommendation 3 of CMS Report 02 be amended by deletion to read as follows:

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 medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs. (Modify Current HOD Policy)

RECOMMENDATION B:

CMS Report 02 be adopted as amended and the remainder of the report be filed.

HOD ACTION: CMS Report 02 adopted as amended and the remainder of report filed

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 medical education including the structure of the

1 program, program curriculum, selection of faculty and trainees, as well as education and
2 disciplinary issues related to these programs. (Modify Current HOD Policy)

3 Your Reference Committee heard supportive testimony for CMS Report 02. There were
4 two amendments proffered by the Integrated Practice Physicians Section (IPPS). There
5 was mixed testimony heard on these amendments. Your Reference Committee heard
6 testimony to strike “use of mandated patient care algorithms” because this topic was not
7 adequately covered by the body of the report. A second amendment to change “Each
8 individual physician” to “Physicians” was offered, but contrary testimony argued against
9 that change. Your Reference Committee concurs that current wording presents no threat
10 to team-based care. Your Reference Committee thanks the Council on Medical Service
11 for a well-written report and recommends the report be adopted as amended and the
12 remainder of the report be filed.

13
14 (5) RESOLUTION 801 – PARITY IN MILITARY
15 REPRODUCTIVE HEALTH INSURANCE COVERAGE
16 FOR ALL SERVICE MEMBERS AND VETERANS

17
18 RECOMMENDATION A:

19
20 Resolution 801 be amended by addition to read as follows:

21
22 RESOLVED, That our American Medical Association support expansion of reproductive health insurance
23 coverage to all active-duty service members and veterans
24 eligible for medical care regardless of service-connected
25 disability, marital status, gender or sexual orientation. (New
26 HOD Policy)
27

28
29 RECOMMENDATION B:

30
31 Resolution 801 be adopted as amended.

32
33 **HOD ACTION: Resolution 801 adopted as amended**

34
35 RESOLVED, That our American Medical Association support expansion of reproductive
36 health insurance coverage to all active-duty service members and veterans eligible for
37 medical care regardless of marital status, gender or sexual orientation. (New HOD
38 Policy)

39
40 Testimony was overwhelmingly supportive of Resolution 801, with several delegations
41 speaking in support. No contrary testimony was heard. There was suggestion for
42 reaffirmation of existing policy, but an amendment was proffered by the American
43 Society of Reproductive Medicine. The Reference Committee believes that with this
44 amendment the resolution is important and novel. Compelling testimony was heard
45 stating that Resolution 801 protects diversity outside of heteronormative identities of
46 those who voluntarily serve our country. We believe this is crucial and thus recommend
47 that Resolution 801 be adopted as amended.

1 (6) RESOLUTION 802 - FAIR HEALTH DATABASE

2
3 RECOMMENDATION A:

4
5 The first Resolve of Resolution 802 be amended by
6 addition and deletion to read as follows:

7
8 RESOLVED, That our American Medical Association
9 advocate ~~to for independent non-conflicted medical charge~~
10 databases of allowed amounts and charges FAIR Health to
11 ensure the continued identification of provider type and the
12 frequency by which a particular CPT© codes are is used.
13 (New HOD Policy)

14
15 RECOMMENDATION B:

16
17 Resolution 802 be amended by addition of a second
18 Resolve clause to read as follows:

19
20 RESOLVED, That our American Medical Association
21 advocate that independent ~~medical charge~~ databases of
22 allowed amounts and charges be transparent on the
23 source of their data, and must validate the data that they
24 directly receive from payors for accuracy against what is
25 actually paid to health care clinicians. (Directive to Take
26 Action)

27
28 RECOMMENDATION C:

29
30 Resolution 802 be adopted as amended.

31
32 RECOMMENDATION D:

33
34 The title of Resolution 802 be changed:

35
36 "INDEPENDENT ~~MEDICAL CHARGE~~ DATABASES OF
37 ALLOWED AMOUNTS AND CHARGES"

38
39 **HOD ACTION: Resolution 802 adopted as amended with a**
40 **change in title to read as follows:**

41
42 "INDEPENDENT ~~MEDICAL CHARGE~~ DATABASES OF
43 ALLOWED AMOUNTS AND CHARGES"

44
45
46 RESOLVED, That our American Medical Association advocate to FAIR Health to ensure
47 the continued identification of the frequency by which a particular CPT code is used.
48 (New HOD Policy)
49

1 Testimony on Resolution 802 was primarily in support. The importance of independent
2 medical charge databases making available frequency codes to identify and assess low
3 volume data cells, as well as the need for transparency of data sources and the provider
4 type of each CPT code were raised by the Dermatology Section Council. The Council on
5 Medical Service testified that to remain consistent across policy, the proprietary
6 language of the original resolution should be replaced with “independent medical charge
7 databases.” This amendment was supported by testimony. Testimony further supported
8 the addition of a second resolve that the AMA advocate for transparency as to the
9 source and validation of data from payors. Your Reference Committee recommends that
10 Resolution 802 be adopted as amended.

11
12 (7) RESOLUTION 809 - UNIFORMITY AND ENFORCEMENT
13 OF MEDICARE ADVANTAGE PLANS AND
14 REGULATIONS

15
16 RECOMMENDATION A:

17
18 The first Resolve of Resolution 809 be amended by
19 deletion to read as follows:

20
21 RESOLVED, That our American Medical Association
22 advocate for better enforcement of Medicare Advantage
23 regulations to hold the Centers for Medicare & Medicaid
24 Services (CMS) accountable for presenting transparency
25 of minimum standards and to determine if those standards
26 are being met for ~~senior~~ physicians and their patients
27 (Directive to Take Action); and be it further
28

29 RECOMMENDATION B:

30
31 Mr. Speaker, your Reference Committee recommends that
32 the second Resolve of Resolution 809 be amended by
33 addition to read as follows:

34
35 RESOLVED, That our AMA advocate that Medicare
36 Advantage plans be required to post all components of
37 Medicare covered and not covered in all plans across the
38 US on their website along with the additional benefits
39 provided (Directive to Take Action); and be it further
40

1 RECOMMENDATION C:

2

3 The third Resolve of Resolution 809 be amended by
4 addition and deletion to read as follows:

5

6 RESOLVED, That our American Medical Association
7 advocate that CMS maintain a publicly available database
8 of physicians in network under Medicare Advantage and
9 the status of each of these physicians in regard to
10 accepting new patients in a manner least burdensome to
11 physicians. ~~provide an accurate, up-to-date list of~~
12 ~~physicians and the plans with which they may or may not~~
13 ~~be accepting as well as if the practice is no longer~~
14 ~~participating, continuing on with current patients, or taking~~
15 ~~new patients for plans that they are contracted for under~~
16 ~~Medicare Advantage.~~ (Directive to Take Action)

17

18 RECOMMENDATION D:

19

20 Resolution 809 be adopted as amended.

21

22 **HOD ACTION: Resolution 809 adopted as amended**

23

24 RESOLVED, That our American Medical Association advocate for better enforcement of
25 Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services
26 (CMS) accountable for presenting transparency of minimum standards and to determine
27 if those standards are being met for senior physicians and their patients (Directive to
28 Take Action); and be it further

29

30 RESOLVED, That our AMA advocate that Medicare Advantage plans be required to post
31 all components of Medicare covered in all plans across the US on their website along
32 with additional benefits provided (Directive to Take Action); and be it further

33

34 RESOLVED, That our AMA advocate that CMS provide an accurate, up-to-date list of
35 physicians and the plans with which they may or may not be accepting as well as if the
36 practice is no longer participating, continuing on with current patients, or taking new
37 patients for plans that they are contracted for under Medicare Advantage. (Directive to
38 Take Action)

39

40 Testimony on Resolution 809 was primarily supportive of the first two Resolves and
41 expressed opposition to the third Resolve as written. The importance of transparency
42 and standardization of provider networks was raised. Specifically, testimony supported
43 the need for patients to have access to what is and is not covered in their plans and for
44 comparison to be possible when selecting a plan.

45

46 Testimony expressed concern for the feasibility of Resolve three as written and the
47 Council on Medical Service suggested alternative language that was supported by
48 further testimony. This language states that the AMA will advocate for CMS to maintain a
49 database of providers and the status of providers accepting new patients in a manner
50 that is least burdensome to physicians. Additional concern was expressed about the

1 original language limiting the database to “senior” physicians and testimony supported
2 the removal of this language. Therefore, your Reference Committee recommends
3 Resolution 809 be adopted as amended.

4
5 (8) RESOLUTION 811 - COVERING VACCINATIONS FOR
6 SENIORS THROUGH MEDICARE PART B

7
8 RECOMMENDATION A:

9
10 Resolution 811 be amended by deletion to read as follows:

11
12 RESOLVED, That our American Medical Association
13 advocate that Medicare ~~Part B~~ cover the full cost of all
14 vaccinations administered to Medicare patients that are
15 recommended by the Advisory Committee on
16 Immunization Practices (ACIP), ~~the US Preventive~~
17 ~~Services Task Force (USPSTF), or based on prevailing~~
18 ~~preventive clinical health guidelines.~~ at the point of care
19 and outside of budget neutrality requirements. (Directive to
20 Take Action)

21
22 RECOMMENDATION B:

23
24 Resolution 811 be adopted as amended.

25
26 RECOMMENDATION C:

27
28 The title of Resolution 811 be changed:

29
30 “COVERING VACCINATIONS THROUGH MEDICARE
31 PART B”

32
33 **HOD ACTION: Resolution 811 adopted as amended with a**
34 **change in title to read as follows:**

35
36 “COVERING VACCINATIONS THROUGH MEDICARE
37 PART B”

38
39 RESOLVED, That our American Medical Association advocate that Medicare Part B
40 cover the full cost of all vaccinations administered to Medicare patients that are
41 recommended by the Advisory Committee on Immunization Practices (ACIP), the US
42 Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical
43 health guidelines. (Directive to Take Action)

44
45 Testimony on Resolution 811 was mostly supportive. Several delegations supported the
46 spirit of the resolution, but there was concerned raised about budget neutrality. There
47 was compelling testimony heard from the U.S. Public Health Service that called for
48 striking “or based on prevailing preventive clinical health guidelines” as this language
49 was ambiguous and unclear. There were amendments proposed to address budget
50 neutrality by a few delegations, including the Council on Medical Service; however, your

1 Reference Committee heard testimony that AMA policy adequately covers our stance on
2 budget neutrality and repeating that here would be redundant. There was testimony from
3 a representative from the RUC also suggesting that this is not the place to address
4 budget neutrality. Your Reference Committee recommends that Resolution 811 be
5 adopted as amended.

6
7 (9) RESOLUTION 812 - IMPLANT-ASSOCIATED
8 ANAPLASTIC LARGE CELL LYMPHOMA

9
10 RECOMMENDATION A:

11
12 Resolution 812 be amended by addition and deletion to
13 read as follows:

14
15 RESOLVED, That our American Medical Association support appropriate coverage of the workup for potential
16 cancer diagnosis, ~~staging, treating surgery~~ locoregional
17 treatment (e.g., surgery or radiation therapy), and other
18 systemic treatment options for breast implant-associated
19 anaplastic large cell lymphoma, breast implant associated
20 squamous cell carcinoma, and other implant associated
21 malignancies. ~~anaplastic large cell lymphoma.~~ (New HOD
22 Policy)

23
24
25 RECOMMENDATION B:

26
27 Resolution 812 be adopted as amended.

28
29 RECOMMENDATION C:

30
31 The title of Resolution 812 be changed:

32
33 "COVERAGE FOR IMPLANT ASSOCIATED
34 MALIGNANCIES"

35
36 **HOD ACTION: Resolution 812 adopted as amended**

37
38 "COVERAGE FOR IMPLANT ASSOCIATED
39 MALIGNANCIES"

40
41 RESOLVED, That our American Medical Association support appropriate coverage of
42 cancer diagnosis, treating surgery and other systemic treatment options for implant-
43 associated anaplastic large cell lymphoma. (New HOD Policy)

44
45 Testimony on Resolution 812 was supportive of the spirit of the resolution, however
46 there were amendments proffered from the American Society of Breast Surgeons and
47 the American Society of Plastic Surgeons to broaden and clarify this language. Your
48 Reference Committee felt that both proffered amendments had merit and we
49 incorporated the language. We recommend that Resolution 812 be adopted as
50 amended.

1
2 (10) RESOLUTION 816 - MEDICAID AND CHIP COVERAGE
3 FOR GLUCOSE MONITORING DEVICES FOR
4 PATIENTS WITH DIABETES

5
6 RECOMMENDATION A:

7
8 The first Resolve of Resolution 816 be amended by
9 addition and deletion to read as follows:

10
11 RESOLVED, That our American Medical Association
12 (AMA) advocate for broadening the classification criteria of
13 Durable Medical Equipment to include all clinically effective
14 ~~and cost saving diabetic~~ continuous or flash glucose
15 monitorings devices (Directive to Take Action); and be it
16 further

17
18 RECOMMENDATION B:

19
20 The second Resolve of Resolution 816 be amended by
21 addition and deletion to read as follows:

22
23 RESOLVED, That our American Medical Association
24 amend Policy H-330.885 by addition and deletion to read
25 as follows:

26
27 Medicare Public Insurance Coverage of Continuous
28 Glucose Monitoring Devices for Patients with Insulin-
29 Dependent Diabetes H-330.885

30
31 Our AMA supports efforts to achieve Medicare coverage of
32 continuous and flash glucose monitoring devices systems
33 for all patients with insulin dependent diabetes by all public
34 insurance programs when it is evidence-based and
35 determined appropriate by physicians. (Modify Current
36 HOD Policy)

37
38 RECOMMENDATION C:

39
40 Resolution 816 be adopted as amended.

41
42 RECOMMENDATION D:

43
44 The title of Resolution 816 be changed:

45
46 "COVERAGE FOR CONTINUOUS OR FLASH GLUCOSE
47 MONITORING DEVICES"

48
49 **HOD ACTION: Resolution 816 adopted as amended with a**
50 **change in title to read as follows**

1
2 "COVERAGE FOR CONTINUOUS OR FLASH
3 GLUCOSE MONITORING DEVICES"
4

5 RESOLVED, That our American Medical Association (AMA) advocate for broadening the
6 classification criteria of Durable Medical Equipment to include all clinically effective and
7 cost-saving diabetic glucose monitors (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA amend AMA Policy H-330.885 by addition and deletion to
10 read as follows:
11

12 ~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for
13 Patients with Insulin-Dependent Diabetes H-330.885
14

15 Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous and flash glucose
16 monitoring systems for all patients with ~~insulin-dependent~~ diabetes by all public
17 insurance programs. (Modify Current HOD Policy)
18

19 Testimony on Resolution 816 was mixed. Delegations supporting the resolution
20 highlighted the success of using continuous glucose monitoring devices with patients,
21 while delegations opposing the resolution noted that this was a very complicated issue
22 that could come with a very high price tag. Testimony from the American College of
23 Obstetricians and Gynecologists noted that this can be used as a method to support
24 patients in managing their glucose and preventing the development of gestational
25 diabetes. The delegation from Florida recommended referral of this item. Testimony
26 largely focused on our proposed amendments to clarify the language, broaden the
27 resolution, and keep physician decision-making at the forefront. The testimony also
28 reflected the use of continuous glucose monitoring devices should be based on well-
29 supported evidence of their effectiveness. Your Reference Committee recommends that
30 Resolution 816 be adopted as amended.

31 (11) RESOLUTION 821 - PREP IS AN ESSENTIAL HEALTH
32 BENEFIT
33

34 RECOMMENDATION A:
35

36 Resolution 821 be amended by addition and deletion to
37 read as follows:
38

39 RESOLVED, That our American Medical Association
40 supports the continued inclusion of Pre-Exposure
41 Prophylaxis (PrEP) for Human Immunodeficiency Virus
42 (HIV) as a Preventive Essential Health Benefit under the
43 Patient Protection and Affordable Care Act (Directive to
44 Take Action); and be it further
45

46 RECOMMENDATION B:
47

48 Resolution 821 be adopted as amended.
49

50 **HOD ACTION: Resolution 821 adopted as amended**

1
2 RESOLVED, That our American Medical Association supports the continued inclusion of
3 Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as an
4 Essential Health Benefit under the Patient Protection and Affordable Care Act (Directive
5 to Take Action); and be it further
6

7 RESOLVED, That our AMA support and join legal efforts to overturn the judgment
8 rendered in *Braidwood v. Becerra* in the U.S. District Court for the Northern District of
9 Texas (Directive to Take Action).

10
11 Testimony on Resolution 821 was unanimously supportive. Pro testimony highlighted
12 that both access to and the affordability of PrEP need to be considered as they are
13 equally important. The new language clarifies that PrEP should be considered a
14 Preventive Essential Health Benefit under the Affordable Care Act, to ensure first-dollar
15 coverage of this life-saving treatment. We recommend Resolution 821 be adopted as
16 amended.
17

18 (12) RESOLUTION 826 - LEVELING THE PLAYING FIELD

19
20 RECOMMENDATION A:

21
22 Resolution 826 be amended by addition of a second
23 Resolve clause to reads as follows:
24

25 RESOLVED, That our AMA consider disseminating the
26 resulting educational materials and graphics. (Directive to
27 Take Action)
28

29 RECOMMENDATION B:

30
31 Resolution 826 be adopted as amended.
32

33 **HOD ACTION: Resolution 826 adopted as amended**
34

35 RESOLVED, That our American Medical Association produce a graphic report
36 illustrating the fiscal losses and inequities that practices without facility fees have
37 endured for decades as a result of the site of service differential factoring in inflation.
38 (Directive to Take Action)
39

40 Mostly supportive testimony was heard on Resolution 826. The Florida delegation
41 proffered an amendment to add a second Resolve clause asking the AMA to send this
42 information to Congress. In order to address the concerns raised by the Dermatology
43 Section Council and maintain the spirit of the amendment, the new language ensures
44 that the AMA is not committed to sending results to Congress before the data has been
45 gathered and the graphics have been created. Therefore, we recommend Resolution
46 826 be adopted as amended.
47

RECOMMENDED FOR ADOPTION IN LIEU OF**(13) RESOLUTION 806 - HEALTHCARE MARKETPLACE
PLAN SELECTION****RECOMMENDATION:**

Alternate Resolution 806 be adopted in lieu of Resolution 806:

RESOLVED, That our AMA re-evaluate and study the effectiveness of the current plan options in the Healthcare Marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA HOD at A-23. (Directive to Take Action)

HOD ACTION: Alternate Resolution 806 adopted in lieu of Resolution 806

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)

Testimony on Resolution 806 was mixed. The Council on Medical Service, the Council on Legislation, the California delegation, and the Medical Student Section recommended reaffirmation and the Young Physician Section recommended this item be referred. Several state delegations spoke in support of this resolution. There were questions raised on the unintended logistical consequences the resolution as written may cause. The Georgia delegation proffered an amendment to address these concerns and your Reference Committee found that the alternate language captures the concerns raised in testimony. Therefore, your Reference Committee recommends Alternate Resolution 806 be adopted in lieu of Resolution 806.

**(14) RESOLUTION 813 - AMENDING POLICY ON A PUBLIC
OPTION TO MAXIMIZE AMA ADVOCACY****RECOMMENDATION:**

Alternate Resolution 813 be adopted in lieu of Resolution 813.

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

3
4 1. That our AMA advocate for a pluralistic health care
5 system, which may include a public option, that focuses on
6 increasing equity and access, is cost-conscious, and
7 reduces burden on physicians.

8
9 2. 4. Our AMA will advocate that any public option to
10 expand health insurance coverage must meet the following
11 standards:

12 a. The primary goals of establishing a public option are to
13 maximize patient choice of health plan and maximize
14 health plan marketplace competition.

15 b. Eligibility for premium tax credit and cost-sharing
16 assistance to purchase the public option is restricted to
17 individuals without access to affordable employer-
18 sponsored coverage that meets standards for minimum
19 value of benefits.

20 c. Physician payments under the public option are
21 established through meaningful negotiations and contracts.
22 Physician payments under the public option must be
23 higher than prevailing Medicare rates and at rates
24 sufficient to sustain the costs of medical practice.

25 d. Physicians have the freedom to choose whether to
26 participate in the public option. Public option proposals
27 should not require provider participation and/or tie
28 physician participation in Medicare, Medicaid and/or any
29 commercial product to participation in the public option.

30 e. The public option is financially self-sustaining and has
31 uniform solvency requirements.

32 f. The public option does not receive advantageous
33 government subsidies in comparison to those provided to
34 other health plans.

35 g. The public option shall be made available to uninsured
36 individuals who fall into the “coverage gap” in states that
37 do not expand Medicaid – having incomes above Medicaid
38 eligibility limits but below the federal poverty level, which is
39 the lower limit for premium tax credits – at no or nominal
40 cost.

41
42 2-3. Our AMA supports states and/or the federal
43 government pursuing auto-enrollment in health insurance
44 coverage that meets the following standards:

45 a. Individuals must provide consent to the applicable state
46 and/or federal entities to share their health insurance
47 status and tax data with the entity with the authority to
48 make coverage determinations.

49 b. Individuals should only be auto-enrolled in health
50 insurance coverage if they are eligible for coverage options

1 that would be of no cost to them after the application of
2 any subsidies. Candidates for auto-enrollment would,
3 therefore, include individuals eligible for
4 Medicaid/Children's Health Insurance Program (CHIP) or
5 zero-premium marketplace coverage.

6 c. Individuals should have the opportunity to opt out from
7 health insurance coverage into which they are auto-
8 enrolled.

9 d. Individuals should not be penalized if they are auto-
10 enrolled into coverage for which they are not eligible or
11 remain uninsured despite believing they were enrolled in
12 health insurance coverage via auto-enrollment.

13 e. Individuals eligible for zero-premium marketplace
14 coverage should be randomly assigned among the zero-
15 premium plans with the highest actuarial values.

16 f. Health plans should be incentivized to offer pre-
17 deductible coverage including physician services in their
18 bronze and silver plans, to maximize the value of zero-
19 premium plans to plan enrollees.

20 g. Individuals enrolled in a zero-premium bronze plan who
21 are eligible for cost-sharing reductions should be notified of
22 the cost-sharing advantages of enrolling in silver plans.

23 h. There should be targeted outreach and streamlined
24 enrollment mechanisms promoting health insurance
25 enrollment, which could include raising awareness of the
26 availability of premium tax credits and cost-sharing
27 reductions, and establishing a special enrollment period.

28
29 3.4. Our AMA: (a) will advocate that any federal approach
30 to cover uninsured individuals who fall into the "coverage
31 gap" in states that do not expand Medicaid--having
32 incomes above Medicaid eligibility limits but below the
33 federal poverty level, which is the lower limit for premium
34 tax credit eligibility--make health insurance coverage
35 available to uninsured individuals who fall into the
36 coverage gap at no or nominal cost, with significant cost-
37 sharing protections; (b) will advocate that any federal
38 approach to cover uninsured individuals who fall into the
39 coverage gap provide states that have already
40 implemented Medicaid expansions with additional
41 incentives to maintain their expansions; (c) supports
42 extending eligibility to purchase Affordable Care Act (ACA)
43 marketplace coverage to undocumented immigrants and
44 Deferred Action for Childhood Arrivals (DACA) recipients,
45 with the guarantee that health plans and ACA
46 marketplaces will not collect and/or report data regarding
47 enrollee immigration status; and (d) recognizes the
48 potential for state and local initiatives to provide coverage
49 to immigrants without regard to immigration status. (Modify
50 Current HOD Policy)

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HOD ACTION: Alternate Resolution 813 adopted in lieu of Resolution 813.

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:

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

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.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.

1 b. Individuals should only be auto-enrolled in health
2 insurance coverage if they are eligible for coverage options
3 that would be of no cost to them after the application of
4 any subsidies. Candidates for auto-enrollment would,
5 therefore, include individuals eligible for
6 Medicaid/Children's Health Insurance Program (CHIP) or
7 zero-premium marketplace coverage.
8 c. Individuals should have the opportunity to opt out from
9 health insurance coverage into which they are auto-
10 enrolled.
11 d. Individuals should not be penalized if they are auto-
12 enrolled into coverage for which they are not eligible or
13 remain uninsured despite believing they were enrolled in
14 health insurance coverage via auto-enrollment.
15 e. Individuals eligible for zero-premium marketplace
16 coverage should be randomly assigned among the zero-
17 premium plans with the highest actuarial values.
18 f. Health plans should be incentivized to offer pre-
19 deductible coverage including physician services in their
20 bronze and silver plans, to maximize the value of zero-
21 premium plans to plan enrollees.
22 g. Individuals enrolled in a zero-premium bronze plan who
23 are eligible for cost-sharing reductions should be notified of
24 the cost-sharing advantages of enrolling in silver plans.
25 h. There should be targeted outreach and streamlined
26 enrollment mechanisms promoting health insurance
27 enrollment, which could include raising awareness of the
28 availability of premium tax credits and cost-sharing
29 reductions, and establishing a special enrollment period.
30
31 3. Our AMA: (a) will advocate that any federal approach to
32 cover uninsured individuals who fall into the "coverage
33 gap" in states that do not expand Medicaid--having
34 incomes above Medicaid eligibility limits but below the
35 federal poverty level, which is the lower limit for premium
36 tax credit eligibility--make health insurance coverage
37 available to uninsured individuals who fall into the
38 coverage gap at no or nominal cost, with significant cost-
39 sharing protections; (b) will advocate that any federal
40 approach to cover uninsured individuals who fall into the
41 coverage gap provide states that have already
42 implemented Medicaid expansions with additional
43 incentives to maintain their expansions; (c) supports
44 extending eligibility to purchase Affordable Care Act (ACA)
45 marketplace coverage to undocumented immigrants and
46 Deferred Action for Childhood Arrivals (DACA) recipients,
47 with the guarantee that health plans and ACA
48 marketplaces will not collect and/or report data regarding
49 enrollee immigration status; and (d) recognizes the
50 potential for state and local initiatives to provide coverage

1 to immigrants without regard to immigration status. (Modify
2 Current HOD Policy)

3 Your Reference Committee heard extensive testimony on Resolution 813. Testimony
4 was mixed and passionate from both sides. To come to a consensus, it seemed that
5 focusing on the similarities rather than the differences in testimony would be most
6 productive. Your Reference Committee heard testimony on Resolution 813 that
7 guardrails were needed when considering support of a public option, that there are
8 barriers to access in the American health care system, and that we need to address
9 health equity, decrease the cost of care, and decrease burdens placed on physicians.

10
11 Your Reference Committee recommends addressing concerns surrounding the
12 guardrails and potential “poison pill” public option programs that would ask the AMA to
13 advocate for a program if it met all of the guidelines listed in H-165.823, regardless of
14 what else was included in that public option program, by returning the clause to its
15 original language.

16
17 To address a more active stance advocating for a public option, your Reference
18 Committee took a “principles first” approach proffering language for a new clause to be
19 added to the beginning of H-165.823. This clause would ask the AMA to advocate for a
20 pluralistic health care system that includes a public option and addresses concerns of
21 equity, access, cost, and burdens on physicians.

22
23 There was concern raised during testimony that this resolution was a way for the AMA to
24 work towards a single-payor system. AMA Policy H-165.888(1b) clearly states that
25 “Unfair concentration of market power of payors is detrimental to patients and
26 physicians, if patient freedom of choice or physician ability to select mode of practice is
27 limited or denied. Single payor systems clearly fall within such a definition and,
28 consequently, should continue to be opposed by the AMA.”

29
30 This alternate resolution addresses the concerns raised and strengthens AMA policy on
31 health system reform. Your Reference Committee recommends Alternate Resolution
32 813 be adopted in lieu of Resolution 813.

33
34 (15) RESOLUTION 814 - SOCIOECONOMICS OF CT
35 CORONARY CALCIUM: IS IT SCORED OR IGNORED?

36
37 RECOMMENDATION:

38
39 Alternate Resolution 814 be adopted in lieu of Resolution
40 814.

41
42 “NATIONAL COVERAGE DETERMINATION OF
43 CORONARY ARTERY CALCIUM SCORING”
44

1 RESOLVED, That our American Medical Association ask
2 the United States Preventive Services Task Force to study
3 the impact of a national coverage determination to include
4 coronary artery calcium scoring for patients who meet the
5 screening criteria. (Directive to Take Action)
6

7 **HOD ACTION: Alternate Resolution 814 adopted in lieu of**
8 **Resolution 814**
9

10 RESOLVED, That our American Medical Association seek national and/or state
11 legislation and/or a national coverage determination (NCD) to include coronary artery
12 calcium scoring (CACS) for patients who meet the screening criteria set forth by the
13 American College of Cardiology/American Heart Association 2019 Primary Prevention
14 Guidelines, as a first-dollar covered preventive service, consistent with the current policy
15 in the state of Texas (Directive to Take Action); and be it further
16

17 RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose
18 that hospitals strongly consider a no cost/nominal cost option for CACS in appropriate
19 patients who are unable to afford this test, as a means to enhance disease detection,
20 disease modification and management. (Directive to Take Action)
21

22 Testimony on Resolution 814 was mixed. The inequity in access to the CACS testing
23 was raised. Testimony outlined the importance of this test, especially in historically
24 underserved and rural communities and populations. Testimony opposing Resolution
25 814 outlined the lack of evidence for CACS and the need for more information to be
26 gathered before the test is recommended via AMA policy. Concern was raised that this
27 is an attempt to legislate around the currently available body of evidence-based
28 literature. Additionally, this concern was raised in the context of inconsistency with
29 existing AMA policy supporting the use of evidence-based practice.
30

31 The USPSTF last studied this issue in 2018 and testimony indicated that there may be
32 new evidence that would be favorable for recommendation for this coverage.
33

34 The Council on Medical Service suggested alternative language that requests that the
35 USPSTF study the impact of a national coverage determination to include CACS for
36 patients who meet the screening criteria. Subsequent testimony was supportive of this
37 language. Therefore, your Reference Committee recommends that Alternate Resolution
38 814 be adopted in lieu of Resolution 814.
39

40 (16) RESOLUTION 815 - OPPOSITION TO DEBT LITIGATION
41 AGAINST PATIENTS
42

43 RECOMMENDATION:
44

45 Resolution 815 not be adopted.
46

47 **HOD ACTION: Alternate Resolution 815 not adopted**
48

49 RESOLVED, That our American Medical Association (AMA) oppose the practice of
50 health care organizations pursuing litigation against patients due to medical debt, and

1 encourages health care organizations to consider the relative financial benefit of
2 collecting medical debt to their revenue, against the detrimental cost to a patient's well-
3 being (New HOD Policy); and be it further

4
5 RESOLVED, That our AMA encourage health care organizations to manage medical
6 debt with patients directly and consider several options, including discounts, payment
7 plans with flexibility and extensions as needed, or forgiveness of debt altogether, before
8 resorting to third-party debt collectors or any punitive actions (New HOD Policy); and be
9 it further

10
11 RESOLVED, That our AMA encourage health care organizations to consider the
12 American Hospital Associate Patient Billing Guidelines when faced with patients
13 struggling to finance their medical bills. (New HOD Policy)

14
15 Testimony for Resolution 815 was mixed. Opposition to Resolution 815 outlined
16 concerns that the removal of debt litigation and forgiveness of debt altogether may result
17 in a "sonic boom" of non-payment as patients may not have the motivation to pay.
18 Additional testimony opposing Resolution 815 was raised the Council on Medical
19 Service, stating that the content of the resolution is adequately covered by existing AMA
20 policy. However, even in testimony opposing Resolution 815 the spirit of health care
21 organizations avoiding litigating against patients was supported.

22
23 Testimony in favor of Resolution 815 outlined the impact of medical debt, especially on
24 historically marginalized communities. The importance of access to health care
25 regardless of socioeconomic status was raised in support of the resolution. In order to
26 maintain the spirit of the original resolution an alternative title and resolution language
27 were recommended. Specifically, the new language outlines a modernized approach to
28 debt litigation, that the AMA consider the relative financial benefit of collecting medical
29 debt against the cost to patient well-being and that physicians work with patients to
30 consider alternative options before initiating litigation or using third-party debt collectors.
31 This revised language captures the spirit of the original resolution, while balancing the
32 concerns that the original language raised. Therefore, your Reference Committee
33 recommends that Alternate Resolution 815 be adopted in lieu of Resolution 815.

34
35 (17) RESOLUTION 817 - PROMOTING ORAL ANTICANCER
36 DRUG PARITY

37
38 RECOMMENDATION:

39
40 Alternate Resolution 817 be adopted in lieu of Resolution
41 817.

42
43 RESOLVED, That our American Medical Association work
44 with interested stakeholders to advocate for cost-sharing
45 parity between injectable/infusable and oral therapy for
46 cancer. (Directive to Take Action)

47
48 **HOD ACTION: Alternate Resolution 817 adopted in lieu**
49 **of Resolution 817**

50

1 RESOLVED, That our American Medical Association amend H-55.986, Home
2 Chemotherapy and Antibiotic Infusions by addition to read as follows:

3
4 H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS

5 Our AMA: (1) endorses the use of home medications to include those orally-
6 administered, injections and/or infusions of FDA approved drugs and group C drugs
7 (including chemotherapy and/or antibiotic therapy) for appropriate patients under
8 physicians' recommendation and supervision; (2) only considers extension of the use of
9 home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy
10 as allowed under the public health emergency when circumstances are present such
11 that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or
12 other insurers to provide adequate reimbursement and liability protections for such
13 treatment; (4) supports educating legislators and administrators about the risks and
14 benefits of such home infused antibiotics and supportive care treatments in terms of cost
15 saving, increased quality of life and decreased morbidity, and about the need to ensure
16 patient and provider safety when considering home infusions for such treatment as
17 biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate
18 reimbursement policies for home infusions; and (6) opposes any requirement by insurers
19 for home administration of drugs, if in the treating physician's clinical judgment it is not
20 appropriate, or the precautions necessary to protect medical staff, patients and
21 caregivers from adverse events associated with drug infusion and disposal are not in
22 place; this includes withholding of payment or prior authorization requirements for other
23 settings-; and (7) advocates for patient cost-sharing parity between office- and home-
24 administered anticancer drugs. (Modify Current HOD Policy)

25
26 Testimony around Resolution 817 was primarily in support with some recommendations
27 for referral. The importance for patients to receive affordable care in the setting and
28 method of their choosing was raised. Additionally, the concerning cost differential
29 between different methods of treatment was stated in support of the resolution. A
30 number of societies and delegations spoke in support of patient ability to receive this
31 treatment in their home if it is determined to be the best course of treatment by the
32 physician and desired by the patient. Testimony opposing Resolution 817 was focused
33 on the need for additional study of this complex issue and suggested that the resolution
34 be referred. However, additional testimony outlined the body of research that exists
35 supporting the use of these types of treatments. Therefore, in order to capture the spirit
36 of proposed amendments, alternative language was suggested that the AMA work with
37 interested stakeholders to advocate for cost-sharing between injectable/infusable and
38 oral therapies for cancer. Therefore, your Reference Committee recommends that
39 Alternate Resolution 817 be adopted in lieu of Resolution 817.

1 (18) RESOLUTION 818 - PEDIATRIC OBESITY TREATMENT
2 INSURANCE COVERAGE
3

4 RECOMMENDATION:
5

6 Alternate Resolution 818 be adopted in lieu of Resolution
7 818:
8

9 RESOLVED, That our American Medical Association
10 amend Policy D-440.954, "Addressing Obesity," by
11 addition and deletion:
12

13 ADDRESSING ADULT AND PEDIATRIC OBESITY D-
14 440.954
15

16 1. Our AMA will: (a) assume a leadership role in
17 collaborating with other interested organizations, including
18 national medical specialty societies, the American Public
19 Health Association, the Center for Science in the Public
20 Interest, and the AMA Alliance, to discuss ways to finance
21 a comprehensive national program for the study,
22 prevention, and treatment of obesity, as well as public
23 health and medical programs that serve vulnerable
24 populations; (b) encourage state medical societies to
25 collaborate with interested state and local organizations to
26 discuss ways to finance a comprehensive program for the
27 study, prevention, and treatment of obesity, as well as
28 public health and medical programs that serve vulnerable
29 populations; and (c) continue to monitor and support state
30 and national policies and regulations that encourage
31 healthy lifestyles and promote obesity prevention.

32 2. Our AMA, consistent with H-440.842, Recognition of
33 Obesity as a Disease, will work with national specialty and
34 state medical societies to advocate for patient access to
35 and physician payment for the full continuum of evidence-
36 based obesity treatment modalities (such as behavioral,
37 pharmaceutical, psychosocial, nutritional, and surgical
38 interventions).

39 3. That our AMA work with interested national medical
40 specialty societies and state medical associations to
41 increase public insurance coverage of and payment for the
42 full spectrum of evidence-based adult and pediatric obesity
43 treatment.

1 3.4. Our AMA will: (a) work with state and specialty
2 societies to identify states in which physicians are
3 restricted from providing the current standard of care with
4 regards to obesity treatment; and (b) work with interested
5 state medical societies and other stakeholders to remove
6 out-of-date restrictions at the state and federal level
7 prohibiting healthcare providers from providing the current
8 standard of care to patients affected by obesity.

9 4.5. Our AMA will leverage existing channels within AMA
10 that could advance the following priorities:

11 · Promotion of awareness amongst practicing physicians
12 and trainees that obesity is a treatable chronic disease
13 along with evidence-based treatment options.

14 · Advocacy efforts at the state and federal level to impact
15 the disease obesity.

16 · Health disparities, stigma and bias affecting people with
17 obesity.

18 · Lack of insurance coverage for evidence-based
19 treatments including intensive lifestyle intervention, anti-
20 obesity pharmacotherapy and bariatric and metabolic
21 surgery.

22 · Increasing obesity rates in children, adolescents and
23 adults.

24 · Drivers of obesity including lack of healthful food choices,
25 over-exposure to obesogenic foods and food marketing
26 practices.

27 5.6. Our AMA will conduct a landscape assessment that
28 includes national level obesity prevention and treatment
29 initiatives, and medical education at all levels of training to
30 identify gaps and opportunities where AMA could
31 demonstrate increased impact.

32 6.7. Our AMA will convene an expert advisory panel once,
33 and again if needed, to counsel AMA on how best to
34 leverage its voice, influence and current resources to
35 address the priorities listed in item 4.5. above. (Modify
36 Current AMA Policy)

37
38 **HOD ACTION: Alternate Resolution 818 adopted in lieu**
39 **of Resolution 818**

40
41 RESOLVED, That our American Medical Association immediately call for full public
42 health insurance coverage of pediatric evidence-based anti-obesity treatment, including
43 comprehensive life-style therapy, anti-obesity medications and metabolic and bariatric
44 surgery (Directive to Take Action); and be it further

45
46 RESOLVED, That our AMA work with all interested parties to lobby the legislative and
47 executive branches of government to affect public health insurance coverage and
48 payment for the full spectrum of evidence-based pediatric anti-obesity therapy. (Directive
49 to Take Action)

1 Testimony on Resolution 818 was mixed. There were amendments proffered by the
2 Council on Medical Service, Young Physician Section, and the American Society of
3 Clinical Oncologists. Testimony generally supported the spirit of this resolution.
4 Addressing childhood obesity is of the utmost importance. The amendment proffered by
5 the Council on Medical Service was compelling and broadens Policy D-440.954 to
6 include pediatric obesity streamlines AMA policy and accomplishes the goal of
7 Resolution 818. The amended language captures the sponsors' ask and calls for
8 increased public health insurance coverage of the full spectrum of evidence-based adult
9 and pediatric obesity treatment, which could include comprehensive lifestyle therapy,
10 anti-obesity medications, and metabolic and bariatric surgery. Your Reference
11 Committee recommends that Alternate Resolution 818 be adopted in lieu of Resolution
12 818.

13

14 (19) RESOLUTION 819 - ADVOCATING FOR THE
15 IMPLEMENTATION OF UPDATED U.S. PREVENTIVE
16 SERVICES TASK FORCE RECOMMENDATIONS FOR
17 COLORECTAL CANCER SCREENING AMONG
18 PRIMARY CARE PHYSICIANS AND MAJOR PAYORS BY
19 THE AMA

20

21 RECOMMENDATION:

22

23 Alternate Resolution 819 be adopted in lieu of Resolution
24 819:

25

26 RESOLVED, That our American Medical Association
27 coordinate with interested national medical specialty
28 societies and state medical associations to enhance
29 physician education and awareness of the US Preventive
30 Services Task Force (USPSTF) guidelines to initiate
31 preventive screening for colorectal cancer at age 45.
32 (Directive to Take Action)

33

34 **HOD ACTION: Alternate Resolution 819 adopted in lieu of**
35 **Resolution 819**

36

37 RESOLVED, That our American Medical Association advocate that payors, health
38 systems, and clinicians adopt the updated U.S. Preventive Task Force Recommendation
39 to initiate routine preventive screening for colorectal cancer at age 45; and to coordinate
40 with like-minded professional organizations to enhance physician education and
41 awareness of this essential recommendation. (Directive to Take Action)

42

43 Testimony was supportive of Resolution 819 outlining the importance of preventative
44 colorectal cancer screening at age 45. A number of medical specialty societies and state
45 medical associations spoke to the importance of ensuring physicians and the public are
46 sufficiently educated and aware of the importance of preventative colorectal cancer
47 screening. The Council on Medical Service spoke in support of the sentiment of
48 Resolution 819, but stated that current AMA policy and advocacy efforts meet the
49 submitted language of the resolution. Alternative language was suggested by the
50 Council on Medical Service that focuses on the need for awareness and education of

1 preventative colorectal cancer screening at age 45. Testimony indicated that coverage
2 included in sections 2713, 4105, and 4106 of the ACA requires adherence to the
3 USPSTF guidelines. Additional testimony supported the new language submitted by the
4 Council on Medical Service. Therefore, your Reference Committee recommends that
5 Alternate Resolution 819 be adopted in lieu of Resolution 819.
6

RECOMMENDED FOR REFERRAL

1
2
3 (20) RESOLUTION 823 - HEALTH INSURERS AND
4 COLLECTION OF CO-PAYS AND DEDUCTIBLES

5
6 RECOMMENDATION:

7
8 Resolution 823 be referred.

9
10 **HOD ACTION: Resolution 823 referred**

11
12 RESOLVED, That our American Medical Association advocate for legislation and/or
13 regulations to require insurers to collect co-pays and deductibles in fee-for-service
14 arrangements directly from patients with whom the insurers are contractually engaged
15 and pay physicians the full contracted rate unless physicians opt out to collect on their
16 own. (Directive to Take Action)

17
18 Testimony on Resolution 823 was limited, but universally supportive. The collection of
19 co-pays and deductibles poses a significant burden on physicians and their practices.
20 However, due to the limited testimony, concern was raised surrounding the unintended
21 consequences of the resolution and its changes to the collection of co-pays and
22 deductibles. AMA policy is very similar to the spirit of Resolution 823, but it remains
23 broader than the submitted resolution. For these reasons and the need for additional
24 research to understand the impact of the spirit of this resolution in a variety of practice
25 settings, your Reference Committee recommends that Resolution 823 be referred.

26
27 (21) RESOLUTION 824 - ENABLING AND ENHANCING THE
28 DELIVERY OF CONTINUITY OF CARE WHEN
29 PHYSICIANS DELIVER CARE ACROSS DIVERSE
30 PROBLEM SETS

31
32 RECOMMENDATION:

33
34 Resolution 824 be referred.

35
36 **HOD ACTION: Resolution 824 referred**

37
38 RESOLVED, That our American Medical Association recognize that there is greater
39 value to the patient, improved access to care, greater patient satisfaction, and improved
40 overall patient care by advocating for appropriate payment for multiple services (two or
41 more) to be performed during a single patient encounter. (Directive to Take Action)

42
43 Testimony on Resolution 824 was mixed. Speakers offered anecdotal evidence as to the
44 issues with existing payment practices and raised that mechanisms for collection of
45 surgery codes are in place but are lacking in E/M codes. Testimony went on to say that
46 the intentionally vague wording of the resolution allowed physicians to provide care in
47 fewer office visits through the combination of care in a single visit. The Council on
48 Medical Service testified that this resolution is adequately covered by AMA policy.
49 Testimony in opposition to Resolution 824 centered around concerns that this policy

1 should be an issue addressed by the RUC and that the AMA should advocate for
2 appropriate evaluation of codes and add on complexity. In order to address given
3 testimony, investigate the complexity of the issue, and better understand how this issue
4 will change with the move to time-based reimbursement in 2023, your Reference
5 Committee recommends Resolution 824 be referred.
6

RECOMMENDED FOR REAFFIRMATION IN LIEU OF**(22) RESOLUTION 804 - CENTERS FOR MEDICARE &
MEDICAID INNOVATION PROJECTS****RECOMMENDATION:**

Resolution 814 be referred for decision.

HOD ACTION: Resolution 804 referred for decision

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)

Testimony on Resolution 804 was mixed. There was testimony in opposition to the second Resolve clause, stating that asking for Congressional approval for CMMI demonstration projects would create unnecessary roadblocks for physicians participating in these programs. Additionally, testimony from the U.S. Public Health Service confirmed that there is already a system in place to take feedback into consideration, noting that most CMMI demonstration projects are voluntary, and only those programs where meaningful improvement data cannot be discerned are reserved for mandatory participation. Without the second Resolve clause, we are left with the first Resolve clause asking for the AMA to advocate against mandatory participation in CMMI demonstration projects. The AMA already has policy supporting this stance. Therefore, your Reference Committee recommends that Policies D-185.950 and H-330.894 be reaffirmed in lieu of Resolution 804.

CMMI PAYMENT REFORM MODELS

Our AMA will: (1) continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and (3) advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties. (Res. 231, A-21)

DEMONSTRATION PROJECT REGARDING MEDICARE PART D H-330.894

1. Our AMA will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D).

1 2. Our AMA encourages the development of voluntary models under the
2 auspices of the CMS Innovation Center (CMMI) to test the impact of offering
3 Medicare beneficiaries additional enhanced alternative health plan choices that
4 offer lower, consistent, and predictable out-of-pocket costs for select prescription
5 drugs. (BOT Action in response to referred for decision Res. 142, A-07;
6 Reaffirmed: CMS Rep. 01, A-17; Appended: CMS Rep. 4, A-22)
7

8 (23) RESOLUTION 808 - REINSTATEMENT OF
9 CONSULTATION CODES

10
11 RECOMMENDATION:

12
13 Policy D-385.955 be reaffirmed in lieu of Resolution 808.

14
15 **HOD ACTION: Policy D-385.955 reaffirmed in lieu of**
16 **Resolution 808**
17

18 RESOLVED, That our American Medical Association proactively engage and advocate
19 with any commercial insurance company that discontinues payment for consultation
20 codes or that is proposing to or considering eliminating payment for such codes,
21 requesting that the company reconsider the policy change. (Directive to Take Action)
22

23 Testimony was mixed for Resolution 808. Testimony supporting Resolution 808 was
24 primarily centered around the need for physicians to be adequately reimbursed.
25 Opposition to Resolution 808 focused entirely on fact that the language of this resolution
26 is verbatim from AMA policy, specifically the first Resolve of AMA Policy D-385.955.
27 Therefore, your Reference Committee recommends that Policy D-385.955 be reaffirmed
28 in lieu of Resolution 808.
29

30 CONSULTATION CODES AND PRIVATE PAYERS D-385.955

31 1. Our AMA will proactively engage and advocate with any commercial insurance
32 company that discontinues payment for consultation codes or that is proposing to
33 or considering eliminating payment for such codes, requesting that the company
34 reconsider the policy change.

35 2. Where a reason given by an insurance company for policy change to
36 discontinue payment of consultation codes includes purported coding errors or
37 abuses, our AMA will request the company carry out coding education and
38 outreach to physicians on consultation codes rather than discontinue payment for
39 the codes, and call for release of de-identified data from the company related to
40 purported coding issues in order to help facilitate potential education by physician
41 societies.
42

43 (24) RESOLUTION 810 - MEDICARE DRUG PRICING AND
44 PHARMACY COSTS

45
46 RECOMMENDATION:

47
48 Policies D-330.954, H-110.987, D-110.994, H-125.978,
49 and H-105.988 be reaffirmed in lieu of Resolution 810.
50

1 **HOD ACTION: Policies D-330.954, H-110.987, D-110.994, H-**
2 **125.978, and H-105.988 reaffirmed in lieu of Resolution 810**
3

4 RESOLVED, That our American Medical Association advocate for immediate, timely and
5 transparent negotiations for how Medicare drug prices are set to be incorporated into law
6 (Directive to Take Action); and be it further
7

8 RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for
9 current medications (commonly known as patent evergreening) (Directive to Take
10 Action); and be it further
11

12 RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for
13 prescription drugs by no later than five years, in 2027. (Directive to Take Action)
14

15 Testimony for Resolution 810 was mixed. The importance of eliminating patent
16 loopholes and the associated “patent evergreening” practice was emphasized as
17 especially important. Testimony also supported the need for affordable prescription
18 drugs through negotiated Medicare drug prices. Opposition to Resolution 810 was
19 centered around the fact that this resolution is adequately covered by existing AMA
20 policies. The Council on Medical Service and the Council on Legislation testified to the
21 coverage of this resolution in AMA Policies D-330.954, H-110.987, D-110.994, H-
22 125.978, and H-105.988, as well as a history of AMA advocacy and recently passed
23 federal legislation supporting the goals of this resolution. Therefore, your Reference
24 Committee recommends that Policies D-330.954, H-110.987, D-110.994, H-125.978,
25 and H-105.988 be reaffirmed in lieu of Resolution 810.
26

27 **PRESCRIPTION DRUG PRICES AND MEDICARE D-330.954**

28 1. Our AMA will support federal legislation which gives the Secretary of the
29 Department of Health and Human Services the authority to negotiate contracts
30 with manufacturers of covered Part D drugs.

31 2. Our AMA will work toward eliminating Medicare prohibition on drug price
32 negotiation.

33 3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid
34 Services to negotiate pharmaceutical pricing for all applicable medications
35 covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res.
36 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended:
37 Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20;
38 Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22)
39

40 **PHARMACEUTICAL COSTS H-110.987**

41 1. Our AMA encourages Federal Trade Commission (FTC) actions to limit
42 anticompetitive behavior by pharmaceutical companies attempting to reduce
43 competition from generic manufacturers through manipulation of patent
44 protections and abuse of regulatory exclusivity incentives.

45 2. Our AMA encourages Congress, the FTC and the Department of Health and
46 Human Services to monitor and evaluate the utilization and impact of controlled
47 distribution channels for prescription pharmaceuticals on patient access and
48 market competition.

49 3. Our AMA will monitor the impact of mergers and acquisitions in the
50 pharmaceutical industry.

- 1 4. Our AMA will continue to monitor and support an appropriate balance between
2 incentives based on appropriate safeguards for innovation on the one hand and
3 efforts to reduce regulatory and statutory barriers to competition as part of the
4 patent system.
- 5 5. Our AMA encourages prescription drug price and cost transparency among
6 pharmaceutical companies, pharmacy benefit managers and health insurance
7 companies.
- 8 6. Our AMA supports legislation to require generic drug manufacturers to pay an
9 additional rebate to state Medicaid programs if the price of a generic drug rises
10 faster than inflation.
- 11 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
- 12 8. Our AMA will convene a task force of appropriate AMA Councils, state medical
13 societies and national medical specialty societies to develop principles to guide
14 advocacy and grassroots efforts aimed at addressing pharmaceutical costs and
15 improving patient access and adherence to medically necessary prescription
16 drug regimens.
- 17 9. Our AMA will generate an advocacy campaign to engage physicians and
18 patients in local and national advocacy initiatives that bring attention to the rising
19 price of prescription drugs and help to put forward solutions to make prescription
20 drugs more affordable for all patients.
- 21 10. Our AMA supports: (a) drug price transparency legislation that requires
22 pharmaceutical manufacturers to provide public notice before increasing the
23 price of any drug (generic, brand, or specialty) by 10% or more each year or per
24 course of treatment and provide justification for the price increase; (b) legislation
25 that authorizes the Attorney General and/or the Federal Trade Commission to
26 take legal action to address price gouging by pharmaceutical manufacturers and
27 increase access to affordable drugs for patients; and (c) the expedited review of
28 generic drug applications and prioritizing review of such applications when there
29 is a drug shortage, no available comparable generic drug, or a price increase of
30 10% or more each year or per course of treatment.
- 31 11. Our AMA advocates for policies that prohibit price gouging on prescription
32 medications when there are no justifiable factors or data to support the price
33 increase.
- 34 12. Our AMA will provide assistance upon request to state medical associations
35 in support of state legislative and regulatory efforts addressing drug price and
36 cost transparency.
- 37 13. Our AMA supports legislation to shorten the exclusivity period for FDA
38 pharmaceutical products where manufacturers engage in anti-competitive
39 behaviors or unwarranted price escalations.
- 40 14. Our AMA supports legislation that limits Medicare annual drug price
41 increases to the rate of inflation. (CMS Rep. 2, I-15Reaffirmed in lieu of: Res.
42 817, I-16Appended: Res. 201, A-17Reaffirmed in lieu of: Res. 207, A-17Modified:
43 Speakers Rep. 01, A-17Appended: Alt. Res. 806, I-17Reaffirmed: BOT Rep. 14,
44 A-18Appended: CMS Rep. 07, A-18Appended: BOT Rep. 14, A-19Reaffirmed:
45 Res. 105, A-19Appended: Res. 113, I-21)
- 46
- 47 INAPPROPRIATE EXTENSION OF PATENT LIFE OF PHARMACEUTICALS D-
48 110.994
- 49 Our AMA will continue to monitor the implementation of the newly-enacted
50 reforms to the Hatch-Waxman law to see if further refinements are needed that

1 would prevent inappropriate extension of patent life of pharmaceuticals, and work
2 accordingly with Congress and the Administration to ensure that AMA policy
3 concerns are addressed. (BOT Rep. 21, A-04; Reaffirmed: BOT Rep. 19, A-14)

4 PATIENT PROTECTION FROM FORCED SWITCHING OF PATENT-
5 PROTECTED DRUGS H-125.978

6 Our AMA will: (1) raise awareness among physicians of the strategy that could
7 be used to limit the value to manufacturers of forced switching of brand
8 formulations of prescription drugs; and (2) advocate that the U.S. Food and Drug
9 Administration (FDA) and Congress ascertain the pervasiveness of this practice
10 and advance solutions that strike an appropriate balance between innovation
11 incentives and competition in order to support patient access to the newest
12 treatments as well as those that are cost-effective. (BOT action in response to
13 referred for decision Res. 219, A-14)

14
15 DIRECT-TO-CONSUMER ADVERTISING (DTCA) OF PRESCRIPTION DRUGS
16 AND IMPLANTABLE DEVICES H-105.988

17 1. To support a ban on direct-to-consumer advertising for prescription drugs and
18 implantable medical devices.

19 2. That until such a ban is in place, our AMA opposes product-claim DTCA that
20 does not satisfy the following guidelines:

21 (a) The advertisement should be indication-specific and enhance consumer
22 education about the drug or implantable medical device, and the disease,
23 disorder, or condition for which the drug or device is used.

24 (b) In addition to creating awareness about a drug or implantable medical device
25 for the treatment or prevention of a disease, disorder, or condition, the
26 advertisement should convey a clear, accurate and responsible health education
27 message by providing objective information about the benefits and risks of the
28 drug or implantable medical device for a given indication. Information about
29 benefits should reflect the true efficacy of the drug or implantable medical device
30 as determined by clinical trials that resulted in the drug's or device's approval for
31 marketing.

32 (c) The advertisement should clearly indicate that the product is a prescription
33 drug or implantable medical device to distinguish such advertising from other
34 advertising for non-prescription products.

35 (d) The advertisement should not encourage self-diagnosis and self-treatment,
36 but should refer patients to their physicians for more information. A statement,
37 such as "Your physician may recommend other appropriate treatments," is
38 recommended.

39 (e) The advertisement should exhibit fair balance between benefit and risk
40 information when discussing the use of the drug or implantable medical device
41 product for the disease, disorder, or condition. The amount of time or space
42 devoted to benefit and risk information, as well as its cognitive accessibility,
43 should be comparable.

44 (f) The advertisement should present information about warnings, precautions,
45 and potential adverse reactions associated with the drug or implantable medical
46 device product in a manner (e.g., at a reading grade level) such that it will be
47 understood by a majority of consumers, without distraction of content, and will
48 help facilitate communication between physician and patient.

49 (g) The advertisement should not make comparative claims for the product
50 versus other prescription drug or implantable medical device products; however,

- 1 the advertisement should include information about the availability of alternative
2 non-drug or non-operative management options such as diet and lifestyle
3 changes, where appropriate, for the disease, disorder, or condition.
- 4 (h) In general, product-claim DTCA should not use an actor to portray a health
5 care professional who promotes the drug or implantable medical device product,
6 because this portrayal may be misleading and deceptive. If actors portray health
7 care professionals in DTCA, a disclaimer should be prominently displayed.
- 8 (i) The use of actual health care professionals, either practicing or retired, in
9 DTCA to endorse a specific drug or implantable medical device product is
10 discouraged but if utilized, the advertisement must include a clearly visible
11 disclaimer that the health care professional is compensated for the endorsement.
- 12 (j) The advertisement should be targeted for placement in print, broadcast, or
13 other electronic media so as to avoid audiences that are not age appropriate for
14 the messages involved.
- 15 (k) In addition to the above, the advertisement must comply with all other
16 applicable Food and Drug Administration (FDA) regulations, policies and
17 guidelines.
- 18 3. That the FDA review and pre-approve all DTCA for prescription drugs or
19 implantable medical device products before pharmaceutical and medical device
20 manufacturers (sponsors) run the ads, both to ensure compliance with federal
21 regulations and consistency with FDA-approved labeling for the drug or
22 implantable medical device product.
- 23 4. That the Congress provide sufficient funding to the FDA, either through direct
24 appropriations or through prescription drug or implantable medical device user
25 fees, to ensure effective regulation of DTCA.
- 26 5. That DTCA for newly approved prescription drug or implantable medical
27 device products not be run until sufficient post-marketing experience has been
28 obtained to determine product risks in the general population and until physicians
29 have been appropriately educated about the drug or implantable medical device.
30 The time interval for this moratorium on DTCA for newly approved drugs or
31 implantable medical devices should be determined by the FDA, in negotiations
32 with the drug or medical device product's sponsor, at the time of drug or
33 implantable medical device approval. The length of the moratorium may vary
34 from drug to drug and device to device depending on various factors, such as:
35 the innovative nature of the drug or implantable medical device; the severity of
36 the disease that the drug or implantable medical device is intended to treat; the
37 availability of alternative therapies; and the intensity and timeliness of the
38 education about the drug or implantable medical device for physicians who are
39 most likely to prescribe it.
- 40 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive
41 programs for physician prescribing and pharmacist dispensing that are run
42 concurrently with DTCA.
- 43 7. That our AMA encourages the FDA, other appropriate federal agencies, and
44 the pharmaceutical and medical device industries to conduct or fund research on
45 the effect of DTCA, focusing on its impact on the patient-physician relationship as
46 well as overall health outcomes and cost benefit analyses; research results
47 should be available to the public.
- 48 8. That our AMA supports the concept that when companies engage in DTCA,
49 they assume an increased responsibility for the informational content and an

1 increased duty to warn consumers, and they may lose an element of protection
2 normally accorded under the learned intermediary doctrine.

3 9. That our AMA encourages physicians to be familiar with the above AMA
4 guidelines for product-claim DTCA and with the Council on Ethical and Judicial
5 Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in
6 that Opinion.

7 10. That the Congress should request the Agency for Healthcare Research and
8 Quality or other appropriate entity to perform periodic evidence-based reviews of
9 DTCA in the United States to determine the impact of DTCA on health outcomes
10 and the public health. If DTCA is found to have a negative impact on health
11 outcomes and is detrimental to the public health, the Congress should consider
12 enacting legislation to increase DTCA regulation or, if necessary, to prohibit
13 DTCA in some or all media. In such legislation, every effort should be made to
14 not violate protections on commercial speech, as provided by the First
15 Amendment to the U.S. Constitution.

16 11. That our AMA supports eliminating the costs for DTCA of prescription drugs
17 as a deductible business expense for tax purposes.

18 12. That our AMA continues to monitor DTCA, including new research findings,
19 and work with the FDA and the pharmaceutical and medical device industries to
20 make policy changes regarding DTCA, as necessary.

21 13. That our AMA supports "help-seeking" or "disease awareness" □
22 advertisements (i.e., advertisements that discuss a disease, disorder, or
23 condition and advise consumers to see their physicians, but do not mention a
24 drug or implantable medical device or other medical product and are not
25 regulated by the FDA).

26 14. Our AMA will advocate to the applicable Federal agencies (including the
27 Food and Drug Administration, the Federal Trade Commission, and the Federal
28 Communications Commission) which regulate or influence direct-to-consumer
29 advertising of prescription drugs that such advertising should be required to state
30 the manufacturer's suggested retail price of those drugs. (BOT Rep. 38 and Sub.
31 Res. 513, A-99Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation
32 I-99Appended & Reaffirmed: Sub. Res. 503, A-01Reaffirmed: Res. 522, A-
33 02Reaffirmed: Res. 914, I-02Reaffirmed: Sub. Res. 504, A-03Reaffirmation A-
34 04Reaffirmation A-05Modified: BOT Rep. 9, A-06Reaffirmed in lieu of Res. 514,
35 A-07BOT Action in response to referred for decision: Res. 927, I-15Modified:
36 BOT Rep. 09, I-16Appended: Res. 236, A-17Reaffirmed in lieu of: Res. 223, A-
37 17Reaffirmed in lieu of: Res. 112, A-19)

38
39 (25) RESOLUTION 822 - MONITORING OF ALTERNATIVE
40 PAYMENT MODELS WITHIN TRADITIONAL MEDICARE

41
42 RECOMMENDATION:

43
44 Resolution 822 be referred.

45
46 **HOD ACTION: Resolution 822 be referred**

47
48 RESOLVED, That our AMA monitor the Accountable Care Organization Realizing
49 Equity, Access, and Community Health (ACO-REACH) program for its impacts on
50 patients and physicians in Traditional Medicare, including the quality and cost of

1 healthcare and patient/provider choice, and report back to the House of Delegates on
2 the impact of the ACO-REACH demonstration program annually until its conclusion
3 (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA advocate against any Medicare demonstration project that
6 denies or limits coverage or benefits that beneficiaries would otherwise receive in
7 Traditional Medicare (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA develop educational materials for physicians regarding the
10 Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-
11 REACH) program to help physicians understand the implications of their or their
12 employer's participation in this program and to help physicians determine whether
13 participation in the program is in the best interests of themselves and their patients.
14 (Directive to Take Action)
15

16 Limited testimony was heard on Resolution 822. The Medical Student Section testified
17 as authors of this resolution stating that ACO-REACH programs need to be monitored
18 and studied. While your Reference Committee appreciated the author's testimony, it
19 does not justify new AMA policy. Your Reference Committee notes that the AMA has
20 strict policy about Medicare Advantage plans being explicit and transparent with
21 patients. We agree that it is important to educate patients on participation in these
22 programs. This notification is already happening and is subject to stringent oversight.
23 Specifically, the second Resolve clause is addressed by H-373.998(5). This policy
24 specifically calls out and addresses patient choice. For these reasons, your Reference
25 Committee recommends that Policies D-160.915, D-385.953, H-373.998, and D-160.923
26 be reaffirmed in lieu of Resolution 822.
27

28 OPPOSITION TO ELIMINATION OF "INCIDENT-TO" BILLING FOR NON-
29 PHYSICIAN PRACTITIONERS D-160.915

30 Our AMA will advocate against efforts to eliminate "incident-to" billing for non-
31 physician practitioners among private and public payors. (Res. 711, A-21)
32

33 DUE DILIGENCE FOR PHYSICIANS AND PRACTICES JOINING AN ACO
34 WITH RISK BASED MODELS (UP SIDE AND DOWN SIDE RISK) D-385.953

35 1. Our AMA will advocate for the continuation of up side only risk Medicare
36 Shared Savings ACO (MSSP ACO) program as an option from the Centers for
37 Medicare and Medicaid Services, particularly for physician owned groups.

38 2. Our AMA will develop educational resources and business tools to help
39 physicians complete due diligence in evaluating the performance of physician-led
40 and hospital integrated systems before considering consolidation. Specific
41 attention should be given to the evaluation of transparency on past savings
42 results, system finances, quality metrics, physician workforce stability and
43 physician job satisfaction, and the cost of clinical documentation software.

44 3. Our AMA will evaluate the characteristics of successful physician owned
45 MSSP ACOs and participation in alternative payment models (APMs) to create a
46 framework of the resources and organizational tools needed to allow practices to
47 form virtual ACOs that would facilitate participation in MSSP ACOs and APMs.
48 (Res. 802, I-18)
49

50 PATIENT INFORMATION AND CHOICE H-373.998

1 Our AMA supports the following principles:

2 1. Greater reliance on market forces, with patients empowered with

3 understandable fee/price information and incentives to make prudent choices,

4 and with the medical profession empowered to enforce ethical and clinical

5 standards which continue to place patients' interests first, is clearly a more

6 effective and preferable approach to cost containment than is a government-run,

7 budget-driven, centrally controlled health care system.

8 2. Individuals should have freedom of choice of physician and/or system of health

9 care delivery. Where the system of care places restrictions on patient choice,

10 such restrictions must be clearly identified to the individual prior to their selection

11 of that system.

12 3. In order to facilitate cost-conscious, informed market-based decision-making in

13 health care, physicians, hospitals, pharmacies, durable medical equipment

14 suppliers, and other health care providers should be required to make

15 information readily available to consumers on fees/prices charged for frequently

16 provided services, procedures, and products, prior to the provision of such

17 services, procedures, and products. There should be a similar requirement that

18 insurers make available in a standard format to enrollees and prospective

19 enrollees information on the amount of payment provided toward each type of

20 service identified as a covered benefit.

21 4. Federal and/or state legislation should authorize medical societies to operate

22 programs for the review of patient complaints about fees, services, etc. Such

23 programs would be specifically authorized to arbitrate a fee or portion thereof as

24 appropriate and to mediate voluntary agreements, and could include the input of

25 the state medical society and the AMA Council on Ethical and Judicial Affairs.

26 5. Physicians are the patient advocates in the current health system reform

27 debate. Efforts should continue to seek development of a plan that will effectively

28 provide universal access to an affordable and adequate spectrum of health care

29 services, maintain the quality of such services, and preserve patients' freedom to

30 select physicians and/or health plans of their choice.

31 6. Efforts should continue to vigorously pursue with Congress and the

32 Administration the strengthening of our health care system for the benefit of all

33 patients and physicians by advocating policies that put patients, and the

34 patient/physician relationships, at the forefront. (BOT Rep. QQ, I-91; Reaffirmed:

35 BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU,

36 A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93;

37 Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93;

38 Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS

39 Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93;

40 Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed:

41 Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94;

42 Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed:

43 Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res.

44 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96;

45 Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97;

46 Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-

47 98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-

48 04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07;

49 Reaffirmation A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-

50 09; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17;

1 Reaffirmed: Res. 108, A-17; Reaffirmation: A-19; Reaffirmed in lieu of: Res. 112,
2 A-19)
3
4 URGE AMA TO RELEASE A WHITE PAPER ON ACOs D-160.923
5 Our AMA will seek objective, independent data on Accountable Care
6 Organizations and release a whitepaper regarding their effect on cost savings
7 and quality of care. (Res. 713, A-17; Reaffirmation: I-17)
8

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee K

Robert H. Emmick Jr., MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

**2
3 RECOMMENDED FOR ADOPTION**

- 4
5 1. Council on Science and Public Health Report 1 – Drug Shortages: 2022 Update
6 2. Resolution 904 - Immigration Status Is a Public Health Issue
7 3. Resolution 918 - Opposition to Alcohol Industry Marketing Self-Regulation
8 4. Resolution 926 - Limit the Pornography Viewing by Minors Over the Internet
9

10 RECOMMENDED FOR ADOPTION AS AMENDED

- 11
12 5. Council on Science and Public Health Report 2 – Climate Change and Human
13 Health
14 6. Resolution 902 - Reducing the Burden of Incarceration on Public Health
15 7. Resolution 905 - Minimal Age of Juvenile Justice Jurisdiction in the United States
16 8. Resolution 907 - A National Strategy for Collaborative Engagement, Study, and
17 Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
18 9. Resolution 908 - Older Adults and the 988 Suicide and Crisis Lifeline
19 10. Resolution 909 - Decreasing Gun Violence and Suicide in Seniors
20 11. Resolution 910 - Gonad Shields: Regulatory and Legislation Advocacy to Oppose
21 Routine Use
22 12. Resolution 915 - Pulse Oximetry in Patients with Pigmented Skin
23 13. Resolution 916 - Non-Cervical HPV Associated Cancer Prevention
24 14. Resolution 919 - Decreasing Youth Access to E-cigarettes
25 15. Resolution 921 - Firearm Injury and Death Research and Prevention
26 16. Resolution 924 - Domestic Production of Personal Protective Equipment
27 17. Resolution 928 - Expanding Transplant Evaluation Criteria to Include Patients that
28 May Not Satisfy Center-Specific Alcohol Sobriety Requirements
29 18. Resolution 929 - Opposing the Marketing of Pharmaceuticals to Parties Responsible
30 for Captive Populations
31 19. Resolution 931 - Amending H-160.903 Eradicating Homelessness to Include Support
32 for Street Medicine Programs
33 20. Resolution 933 - Reducing Disparities in HIV Incidence through Pre-Exposure
34 Prophylaxis (PrEP) for HIV
35

36 RECOMMENDED FOR ADOPTION IN LIEU OF
37

- 1 21. Resolution 906 - Requirement for COVID-19 Vaccination in Public Schools Once
 2 Fully FDA-Authorized
- 3 22. Resolution 912 - Reevaluating the Food and Drug Administration's Citizen Petition
 4 Process
- 5 23. Resolution 930 - Addressing Longitudinal Health Care Needs of Children in Foster
 6 Care
- 7 **RECOMMENDED FOR REFERRAL**
- 8
- 9 24. Resolution 901 - Opposing the Use of Vulnerable Incarcerated People in Response
 10 to Public Health Emergencies
- 11 25. Resolution 913 - Supporting and Funding Sobering Centers
- 12 26. Resolution 935 - Government Manufacturing of Generic Drugs to Address Market
 13 Failures
- 14 27. Resolution 937 - Indications for Metabolic and Bariatric Surgery
- 15 28. Resolution 938 - AMA Study of Efficacy of Requirements for Metal
 16 Detection/Weapons Interdiction Systems in Health Care Facilities
- 17
- 18 **RECOMMENDED FOR REFERRAL FOR DECISION**
- 19
- 20 29. Resolution 911 - Critical Need for National Emergency Cardiac Care (ECC) System
 21 to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial
 22 Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest
 23 (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac
 24 Emergencies
- 25 30. Resolution 917 - Care for Children with Obesity
- 26 31. Resolution 923 - Physician Education and Intervention to Improve Patient Firearm
 27 Safety
- 28 32. Resolution 936 - Promoting the Use of Multi-Use Devices and Sustainable Practices
 29 in the Operating Room

For the purposes of clarity, items marked with double underline or ~~double strikethrough~~ are highlighted in yellow.

Amendments

If you wish to propose an amendment to an item of business, click here: [Submit New Amendment](#)

The following resolutions were handled via the reaffirmation consent calendar or were recommended not for consideration:

- Resolution 903 - Supporting Further Study of Kratom
- Resolution 914 - Greenhouse Gas Emissions from Health Care
- Resolution 922 - Firearm Safety and Technology
- Resolution 925 - Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA
- Resolution 927 - Off-Label Policy
- Resolution 932 - Increase Employment Services Funding for People with Disabilities
- Resolution 934 - Denouncing the use of Solitary Confinement in Correctional Facilities and Detention Centers

1

- Resolution 939 - Mattress Safety in the Hospital Setting

RECOMMENDED FOR ADOPTION

- 1
2
3 (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
4 1 – DRUG SHORTAGES: 2022 UPDATE
5

RECOMMENDATION:

6
7
8 Recommendations in Council on Science and Public Health
9 Report 1 be adopted and the remainder of the report filed.

10
11 **HOD ACTION: Recommendations in Council on**
12 **Science and Public Health Report 1 adopted and the**
13 **remainder of the report filed**
14

15 The Council on Science and Public Health recommends that the following be adopted, and
16 the remainder of the report be filed.

17
18 1) Policy H-100.956, “National Drug Shortages” be amended by addition to read as follows:
19

20 1. Our AMA considers drug shortages to be an urgent public health crisis, and recent
21 shortages have had a dramatic and negative impact on the delivery and safety of appropriate
22 health care to patients.

23
24 2. Our AMA supports recommendations that have been developed by multiple stakeholders
25 to improve manufacturing quality systems, identify efficiencies in regulatory review that can
26 mitigate drug shortages, and explore measures designed to drive greater investment in
27 production capacity for products that are in short supply, and will work in a collaborative
28 fashion with these and other stakeholders to implement these recommendations in an urgent
29 fashion.

30
31 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human
32 Services (DHHS) to expedite facility inspections and the review of manufacturing changes,
33 drug applications and supplements that would help mitigate or prevent a drug shortage.

34
35 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress
36 require drug manufacturers to establish a plan for continuity of supply of vital and life-
37 sustaining medications and vaccines to avoid production shortages whenever possible. This
38 plan should include establishing the necessary resiliency and redundancy in manufacturing
39 capability to minimize disruptions of supplies in foreseeable circumstances including the
40 possibility of a disaster affecting a plant.

41
42 5. The Council on Science and Public Health shall continue to evaluate the drug shortage
43 issue, including the impact of group purchasing organizations and pharmacy benefit
44 managers on drug shortages, and report back at least annually to the House of Delegates on
45 progress made in addressing drug shortages.

46
47 6. Our AMA urges continued analysis of the root causes of drug shortages that includes
48 consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization
49 (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market

1 participants on competition, access to drugs, pricing, and analysis of economic drivers, and
2 supports efforts by the Federal Trade Commission to oversee and regulate such forces.

3
4 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs
5 by ensuring that such products are not removed from the market or caused to stop production
6 due to compliance issues unless such removal is clearly required for significant and obvious
7 safety reasons.

8
9 2. That Policy H-440.847, "Pandemic Preparedness," which addresses the adequacy of the
10 Strategic National Stockpile, be reaffirmed. (Reaffirm HOD Policy)

11
12 Your Reference Committee heard testimony that was largely supportive of the Council's report
13 on drug shortages. An amendment was proposed requesting that the Department of Health
14 and Human Services, Office of the Inspector General look into existing pharmaceutical
15 contracts. Since this is an annual report by the Council, we encourage the Council to examine
16 this issue in their next drug shortage report. Therefore, your Reference Committee
17 recommends that the recommendations in Council on Science and Public Health Report 1 be
18 adopted.

19
20 (2) RESOLUTION 904 - IMMIGRATION STATUS IS A PUBLIC
21 HEALTH ISSUE

22
23 **RECOMMENDATION:**

24
25 Resolution 904 be adopted.

26
27 **HOD ACTION: Resolution 904 adopted.**

28
29 RESOLVED, That our American Medical Association declare that immigration status is a
30 public health issue that requires a comprehensive public health response and solution
31 (Directive to Take Action); and be it further

32
33 RESOLVED, That our AMA recognize interpersonal, institutional, structural, and systemic
34 factors that negatively affect immigrants' health (New HOD Policy); and be it

35
36 RESOLVED, That our AMA promote the development and implementation of educational
37 resources for healthcare professionals to better understand health and healthcare challenges
38 specific for the immigrant population (Directive to Take Action); and be it further

39
40 RESOLVED, That our AMA support the development and implementation of public health
41 policies and programs that aim to improve access to healthcare

42
43 Your Reference Committee heard testimony broadly supportive of Resolution 904. Testimony
44 in support cited the resolutions alignment with current AMA policy and noted that immigration
45 status is negatively linked to an individual's health. Testimony in opposition noted that this
46 issue is complex and sought clarification on the role of legal status and the socioeconomic
47 factors that impact the overall health of immigrants. Your Reference Committee notes that this
48 resolution focuses on immigration status and not the legality of immigration status. Therefore,
49 your Reference Committee recommends that Resolution 904 be adopted.

1 (3) RESOLUTION 918 – OPPOSITION TO ALCOHOL
2 INDUSTRY MARKETING SELF-REGULATION
3

4 **RECOMMENDATION:**

5
6 Resolution 918 be adopted.

7
8 **HOD ACTION: Resolution 918 adopted.**
9

10 RESOLVED, That our American Medical Association amend policy H-30.940, "Labeling
11 Advertising, and Promotion of Alcoholic Beverages," by addition and deletion to read as
12 follows:

13
14 **H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages**

15 (1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all
16 beverages, including so-called "nonalcoholic" beer and other substances as well, including
17 over-the-counter and prescription medications, with removal of "nonalcoholic" from the label
18 of any substance containing any alcohol; (b) supports efforts to educate the public and
19 consumers about the alcohol content of so-called "nonalcoholic" beverages and other
20 substances, including medications, especially as related to consumption by minors; (c) urges
21 the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal
22 regulatory agencies to continue to reject proposals by the alcoholic beverage industry for
23 authorization to place beneficial health claims for its products on container labels; and (d)
24 urges the development of with the Nutritional Labeling and Education Act.

25 (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons
26 under 21 years of age, which creates an image of drinking alcoholic beverages and thereby
27 may encourage the illegal underaged use of alcohol; (b) recommends that health education
28 labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising
29 (with the messages focusing on the hazards of alcohol consumption by specific population
30 groups especially at risk, such as pregnant women, as well as the dangers of irresponsible
31 use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be
32 encouraged to accurately label all product containers as to ingredients, preservatives, and
33 ethanol content (by percent, rather than by proof).

34 (3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic
35 beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a)
36 supports federal and/or state oversight for all forms of alcohol advertising in lieu of the alcohol
37 industry's current practice of self-regulated advertising and marketing; ~~(a)~~(b) supports
38 continued research, educational, and promotional activities dealing with issues of alcohol
39 advertising and health education to provide more definitive evidence on whether, and in what
40 manner, advertising contributes to alcohol abuse; ~~(b)~~(c) opposes the use of the radio and
41 television any form of advertising which links alcoholic products to agents of socialization in
42 order to promote drinking; ~~(e)~~(d) will work with state and local medical societies to support the
43 elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges
44 college and university authorities to bar alcoholic beverage companies from sponsoring
45 athletic events, music concerts, cultural events, and parties on school campuses, and from
46 advertising their products or their logo in school publications; and ~~(e)~~(f) urges its constituent
47 state associations to support state legislation to bar the promotion of alcoholic beverage
48 consumption on school campuses and in advertising in school publications.

49 (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising
50 directed toward youth, including such as promotions on high school and college campuses;
51 (b) urges advertisers and broadcasters to cooperate in eliminating television program content

1 that depicts the irresponsible use of alcohol without showing its adverse consequences
2 (examples of such use include driving after drinking, drinking while pregnant, or drinking to
3 enhance performance or win social acceptance); (e) supports continued warnings against the
4 irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include
5 in their advertising specific warnings against driving after drinking; and (f) commends those
6 automobile and alcoholic beverage companies that have advertised against driving while
7 under the influence of alcohol. (Modify Current HOD Policy)

8
9 Your Reference Committee heard limited, but unanimously supportive testimony on this
10 resolution. Testimony noted the deleterious effects of alcohol on health and the limited
11 success of the alcohol industry's self-regulation of marketing practices. Therefore, your
12 Reference Committee recommends that Resolution 918 be adopted.

13
14 (4) RESOLUTION 926 – LIMIT THE PORNOGRAPHY
15 VIEWING BY MINORS OVER THE INTERNET

16
17 **RECOMMENDATION:**

18
19 **Resolution 926 be adopted.**

20
21 **HOD ACTION: Resolution 926 adopted.**

22
23 RESOLVED, That our American Medical Association amend existing policy H-60.934,
24 "Internet Pornography Protecting Children and Youth Who Use the Internet and Social Media,"
25 by addition to read as follows:

26 Our AMA:

27 (1) Recognizes the positive role of the Internet in providing health information to children and
28 youth.

29 (2) Recognizes the negative role of the Internet in connecting children and youth to predators
30 and exposing them to pornography.

31 (3) Supports federal legislation that restricts Internet access to pornographic materials in
32 designated public institutions where children and youth may use the Internet.

33 (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the
34 importance of educating their children about safe Internet and social media use.

35 (5) Supports school-based media literacy programs that teach effective thinking, learning, and
36 safety skills related to Internet and social media use.

37 (6) Actively support legislation that would strengthen child-centric content protection by
38 internet service providers and/or search engines in order to limit the access of pornography
39 to minors on the internet and mobile applications. (Modify Existing Policy)

40
41 Your Reference Committee heard unanimously supportive testimony for this resolution.
42 Testimony noted the dramatic change that has occurred in the past decades regarding access
43 to pornography, and how children now may inadvertently see pornography on the internet
44 even if not seeking it out. As such, your Reference Committee recommends that this resolution
45 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

1
2
3 (5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
4 2 – CLIMATE CHANGE AND HUMAN HEALTH
5

RECOMMENDATION A:

6
7
8 The second Recommendation in Council on Science and
9 Public Health Report 2 be amended by addition and deletion
10 to read as follows:
11

12 Our AMA: 1. Supports ~~the findings of the Intergovernmental~~
13 ~~Panel on Climate Change's fourth assessment report and~~
14 ~~concurs with the~~ scientific consensus that the Earth is
15 undergoing adverse global climate change and that
16 anthropogenic contributions are significant. These climate
17 changes have adversely affected the physical and mental
18 health of people. will create conditions that affect public
19 health, with We recognize that minoritized and marginalized
20 populations, children, pregnant people, the elderly, rural
21 communities, and those who are economically
22 disadvantaged will suffer disproportionate impacts harms
23 from of climate change on vulnerable populations, including
24 children, the elderly, and the poor.
25

RECOMMENDATION B:

26
27
28 The third Recommendation in Council on Science and
29 Public Health Report 2 be amended by addition and deletion
30 to read as follows:
31

32 3. That Policy D-150.978, "Sustainable Food" be reaffirmed.
33

34 Our AMA: (1) supports practices and policies in medical
35 schools, hospitals, and other health care facilities that
36 support and model a healthy and ecologically sustainable
37 food system, which provides food and beverages of
38 naturally high nutritional quality; (2) ~~encourages the~~
39 ~~development of a healthier food system~~ supports sustained
40 funding for evidence-based policies and programs to
41 eliminate disparities in healthy food access, particularly for
42 populations vulnerable to food insecurity, through measures
43 such as through tax incentive programs, community-level
44 initiatives and federal legislation; and (3) will consider
45 working with other health care and public health
46 organizations to educate the health care community and the
47 public about the importance of healthy and ecologically
48 sustainable food systems. (Reaffirm Modify HOD Policy)

1 **RECOMMENDATION C:**

2

3 Recommendations in Council on Science and Public Health
4 Report 2 be adopted as amended and the remainder of the
5 report filed.

6

7 **RECOMMENDATION D:**

8

9 That policies H-135.921, “AMA to Protect Human Health
10 from the Effects of Climate Change by Ending its
11 Investments in Fossil Fuel Companies” and D-135.969,
12 “AMA to Protect Human Health from the Effects of Climate
13 Change by Ending its Investments in Fossil Fuel
14 Companies” be reaffirmed.

15

16 **HOD ACTION: Recommendations in Council on Science
17 and Public Health Report 2 adopted as amended and
18 remainder of the report filed. Policies H-135.921, “AMA
19 to Protect Human Health from the Effects of Climate
20 Change by Ending its Investments in Fossil Fuel
21 Companies” and D-135.969, “AMA to Protect Human
22 Health from the Effects of Climate Change by Ending its
23 Investments in Fossil Fuel Companies” be reaffirmed.**

24

25 The Council on Science and Public Health recommends that the following be adopted and the
26 remainder of the report be filed.

27

28 1. That Policy D-135.966, “Declaring Climate Change a Public Health Crisis” be amended by
29 addition to read as follows:

30

31 1. Our AMA declares climate change a public health crisis that threatens the health and well-
32 being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a)
33 limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas
34 emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by
35 2050, and (c) support rapid implementation and incentivization of clean energy solutions and
36 significant investments in climate resilience through a climate justice lens. 3. Our AMA
37 consider signing on to the Department of Health and Human Services Health Care Pledge or
38 making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA
39 encourages the health sector to lead by example in committing to carbon neutrality by 2050.
40 5. Our AMA will develop a strategic plan for how we will enact our climate change policies
41 including advocacy priorities and strategies to decarbonize physician practices and the health
42 sector with report back to the House of Delegates at the 2023 Annual Meeting. (Modify Current
43 HOD Policy)

44

45 2. That Policy H-135.938, “Global Climate Change and Human Health” be amended by
46 addition and deletion to read as follows:

47

48 Our AMA: 1. Supports ~~the findings of the Intergovernmental Panel on Climate Change's fourth~~
49 ~~assessment report and concurs with the scientific consensus that the Earth is undergoing~~
50 adverse global climate change and that anthropogenic contributions are significant. These
51 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)

1 Testimony for this item was robust and largely supportive. The Council was praised for this
2 initial report updating our AMA's position on climate change. A member of the Board of
3 Trustees also noted their upcoming report outlining the AMA's strategy on climate change and
4 health. Several amendments were offered that your Reference Committee agreed with
5 including: 1) to add pregnant people to the list of populations that will suffer disproportionate
6 impacts, 2) to strengthen existing policy around climate change and food insecurity, and 3) to
7 reaffirm the AMA's existing policies related to divestment from fossil fuels. There were some
8 additional amendments that your Reference Committee believes are outside of the scope of
9 this report, including adding language around nutritional guidelines. Therefore, your
10 Reference Committee recommends that CSAPH Report 2 be adopted as amended.

11
12 Policies recommended for reaffirmation:

13
14 H-135.921 AMA to Protect Human Health from the Effects of Climate Change by
15 Ending its Investments in Fossil Fuel Companies

16 1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible,
17 vendors, suppliers, and corporations that have demonstrated environmental
18 sustainability practices that seek to minimize their fossil fuels consumption; and (b)
19 support efforts of physicians and other health professional associations to proceed
20 with divestment, including to create policy analyses, support continuing medical
21 education, and to inform our patients, the public, legislators, and government policy
22 makers.

23
24 2. Our AMA: (a) declares that climate change is an urgent public health emergency,
25 and calls upon all governments, organizations, and individuals to work to avert
26 catastrophe; (b) urges all health and life insurance companies, including those that
27 provide insurance for medical, dental, and long-term care, to work in a timely,
28 incremental, and fiscally responsible manner to end all financial investments or
29 relationships (divestment) with companies that generate the majority of their income
30 from the exploration for, production of, transportation of, or sale of fossil fuels; and (c)
31 will send letters to the nineteen largest health or life insurance companies in the United
32 States to inform them of AMA policies concerned with climate change and with fossil
33 fuel divestments, and urging these companies to divest.

34
35 D-135.969 AMA to Protect Human Health from the Effects of Climate Change by
36 Ending its Investments in Fossil Fuel Companies

37 Our AMA, AMA Foundation, and any affiliated corporations will work in a timely,
38 incremental, and fiscally responsible manner, to the extent allowed by their legal and
39 fiduciary duties, to end all financial investments or relationships (divestment) with
40 companies that generate the majority of their income from the exploration for,
41 production of, transportation of, or sale of fossil fuels.

42
43 (6) RESOLUTION 902 – REDUCING THE BURDEN OF
44 INCARCERATION ON PUBLIC HEALTH

45
46 **RECOMMENDATION A:**

47
48 That the second Resolve of Resolution 902 be amended by
49 addition and deletion to read as follows:

1 RESOLVED, That our AMA partner with ~~the American~~
2 ~~Public Health Association~~ public health organizations and
3 other interested stakeholders to urge Congress, the
4 Department of Justice, ~~and~~ the Department of Health and
5 Human Services, and state officials and agencies to
6 minimize the negative health effects of incarceration by
7 supporting programs that facilitate employment at a living
8 wage, and safe, affordable ~~and~~ housing opportunities for
9 formerly incarcerated individuals, as well as research into
10 alternatives to incarceration. (Directive to Take Action)

11
12 **RECOMMENDATION B:**

13
14 Resolution 902 be adopted as amended.

15
16 **HOD ACTION: Resolution 902 adopted as amended.**

17
18 RESOLVED, That our American Medical Association support efforts to reduce the negative
19 health impacts of incarceration, such as: (1) implementation and incentivization of adequate
20 funding and resources towards indigent defense systems; (2) implementation of practices that
21 promote access to stable employment and laws that ensure employment non-discrimination
22 for workers with previous non-felony criminal records; and (3) housing support for formerly
23 incarcerated people, including programs that facilitate access to immediate housing after
24 release from carceral settings (New HOD Policy); and be it further

25
26 RESOLVED, That our AMA partner with the American Public Health Association and other
27 stakeholders to urge Congress, the Department of Justice, and the Department of Health and
28 Human Services to minimize the negative health effects of incarceration by supporting
29 programs that facilitate employment and housing opportunities for formerly incarcerated
30 individuals as well as research into alternatives to incarceration. (Directive to Take Action)

31
32 Your Reference Committee heard testimony in support of Resolution 902. It was noted that
33 although addressing the burden of incarceration on public health will be complex, the
34 resolution provides important additions to existing policy. An amendment was proffered to
35 address the need for a livable wage and access to affordable housing opportunities, noting
36 that these issues often impact successfully returning into society. Your Reference Committee
37 agrees with this amendment. Further, an amendment was proffered to include state officials
38 and agencies to the list of possible partner organizations and your Reference Committee
39 agrees with this amendment. Your Reference Committee also noted that our AMA should
40 partner with public health organizations broadly as well as other interested stakeholders.
41 Therefore, your Reference Committee recommends that Resolution 902 be adopted as
42 amended.

43
44 (7) RESOLUTION 905 – MINIMAL AGE OF JUVENILE
45 JUSTICE JURISDICTION IN THE UNITED STATES

46
47 **RECOMMENDATION A:**

48
49 The first Resolve of Resolution 905 be amended by addition
50 and deletion to read as follows:

1 RESOLVED, That our American Medical Association create
2 a policy to establish minimal age of ~~10~~ 14 years for juvenile
3 justice jurisdiction in the United States (New HOD Policy)

4

5 **RECOMMENDATION B:**

6

7 The second Resolve of Resolution 905 be amended by
8 addition and deletion to read as follows:

9

10 RESOLVED, That our AMA ~~introduce~~ develop model
11 legislation to establish minimal age of ~~10~~ 14 for juvenile
12 justice jurisdiction in the United States. (Directive to Take
13 Action)

14

15 **RECOMMENDATION C:**

16

17 Resolution 905 be adopted as amended.

18

19 **HOD ACTION: Resolution 905 adopted as amended.**

20

21 RESOLVED, That our American Medical Association create a policy to establish minimal age
22 of 10 years for juvenile justice jurisdiction in the United States (New HOD Policy); and be it
23 further

24

25 RESOLVED, That our AMA introduce legislation to establish minimal age of 10 for juvenile
26 justice jurisdiction in the United States. (Directive to Take Action)

27

28 Your Reference Committee heard testimony in support of the intent of Resolution 905.
29 Amendments were proposed to change the minimum age from 10 to 14, citing evidence and
30 consensus statements. While there was some testimony in support of referral of this
31 resolution, others noted referral is not necessary given the available evidence. Your
32 Reference Committee notes that our AMA cannot introduce legislation, but could develop
33 model legislation for dissemination. Your Reference Committee supports these amendments
34 and recommends Resolution 905 be adopted as amended.

35

36 (8) RESOLUTION 907 – A NATIONAL STRATEGY FOR
37 COLLABORATIVE ENGAGEMENT, STUDY, AND
38 SOLUTIONS TO REDUCE THE ROLE OF ILLEGAL
39 FIREARMS IN FIREARM RELATED INJURY

40

41 **RECOMMENDATION A:**

42

43 That the first Resolve of Resolution 907 be amended by
44 addition and deletion to read as follows:

45

46 RESOLVED, That our American Medical Association
47 support research ~~looking at~~ examining the major sources of
48 illegally possessed firearms gun supply, as well as possible
49 methods of decreasing their proliferation of illegally firearms
50 in the United States (New HOD Policy); and be it further

RECOMMENDATION B:

That the second Resolve of Resolution 907 be amended by deletion to read as follows:

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 groups, 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 ~~illegally possessed~~ firearms (Directive to Take Action); and be it further

RECOMMENDATION C:

That the third Resolve of Resolution 907 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~convene~~ collaborate with key stakeholders and advocate for 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 ~~illegally possessed~~ firearms in our firearm injury public health crisis (Directive to Take Action)

RECOMMENDATION D:

Resolution 907 be adopted as amended.

RECOMMENDATION E:

That the title of Resolution 907 be changed to read as follows:

A NATIONAL STRATEGY FOR COLLABORATIVE ENGAGEMENT, STUDY, AND SOLUTIONS TO REDUCE THE ROLE OF ILLEGALLY POSSESSED FIREARMS IN FIREARM RELATED INJURY

HOD ACTION: Resolution 907 adopted as amended with a change in title to read as follows:

A NATIONAL STRATEGY FOR COLLABORATIVE ENGAGEMENT, STUDY, AND SOLUTIONS TO REDUCE THE ROLE OF ILLEGALLY POSSESSED FIREARMS IN FIREARM RELATED INJURY

1 RESOLVED, That our American Medical Association support research looking at the major
2 sources of illegal gun supply, as well as possible methods of decreasing the proliferation of
3 illegal firearms in the United States (New HOD Policy); and be it further

4
5 RESOLVED, That our AMA work with key stakeholders including, but not limited to, firearm
6 manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies,
7 firearm injury victims advocacy groups, healthcare providers, and state and federal
8 government agencies to study and develop evidence-informed public health
9 recommendations to mitigate the effects of violence committed with illegal firearms (Directive
10 to Take Action); and be it further

11
12 RESOLVED, That our AMA convene national public forums including, but not limited to, online
13 venues, national radio, and televised/streamed in-person town halls, that bring together key
14 stakeholders and members of the general public to focus on finding common ground, non-
15 partisan measures to mitigate the effects of illegal firearms in our firearm injury public health
16 crisis (Directive to Take Action); and be it further

17
18 RESOLVED, That our AMA reaffirm House policies H-145.975, H-145.984, H-145.997, D-
19 145.994, and D-145.999 calling for increased funding for national firearm violence research.
20 (Reaffirm HOD Policy)

21
22 Your Reference Committee heard testimony that was mostly supportive of the intent of this
23 resolution, but several amendments were offered to clarify the scope. Some of the discussion
24 was centered around the framing of “illegal” firearms noting that whether or not a firearm is
25 “illegal” is dependent on the laws of a jurisdiction. To help address this your Reference
26 Committee amended the language changing it to “illegally possessed firearms.” On the
27 second Resolve, your Reference Committee believes that that a study is unnecessary if our
28 AMA is working with stakeholders to develop evidence-informed recommendations and
29 amended the language accordingly. Additional testimony was provided noting the high fiscal
30 note of the resolution, this was addressed in part by an amendment calling on our AMA to
31 collaborate with stakeholders to convene national forums, rather than having our AMA lead
32 the convening. Therefore, your Reference Committee recommends Resolution 907 be
33 adopted as amended.

34
35 (9) RESOLUTION 908 – OLDER ADULTS AND THE 988
36 SUICIDE AND CRISIS LIFELINE

37
38 **RECOMMENDATION A:**

39
40 Policy D-345.974, “Awareness Campaign for 988 National
41 Suicide Prevention Lifeline” be amended by addition and
42 deletion to read as follows:

43
44 Our AMA will: (1) utilize their existing communications
45 channels to educate the physician community and the public
46 on the new 9-8-8 National Suicide Prevention Lifeline
47 program; (2) work with the Federation and other
48 stakeholders to advocate for adequate federal and state
49 funding for the 9-8-8 system, including the development of
50 model legislation; and (3) collaborate with the Substance
51 Abuse and Mental Health Services Administration, ~~and~~ the

1 9-8-8 partner community, and other interested stakeholders,
2 to strengthen suicide prevention and mental health crisis
3 services that prioritize education and outreach to those
4 populations at highest risk for suicide attempts, suicide
5 completions, and self-injurious behavior.
6

7 **RECOMMENDATION B:**

8
9 Policy D-345.974 be adopted as amended in lieu of
10 Resolution 908.

11
12 **HOD ACTION: Policy D-345.974 adopted as amended in**
13 **lieu of Resolution 908.**
14

15 RESOLVED, That our American Medical Association, with other interested organizations,
16 develop model legislation for use by states who wish to pursue funding for the 988 Suicide
17 and Crisis Lifeline (Directive to Take Action); and be it further
18

19 RESOLVED, That our AMA advocate that the Department of Health and Human Services
20 (HHS) prioritize education and outreach activities for use of the 988 Suicide and Crisis Lifeline
21 to those who are at highest risk for suicide completion with a special emphasis on those over
22 age 65. (Directive to Take Action)
23

24 Your Reference Committee heard testimony unanimously supportive of this resolution. Since
25 our House of Delegates just adopted policy on the 988 Suicide and Crisis Lifeline, your
26 Reference Committee felt it appropriate to incorporate the proposed amendments into our
27 existing policy in order to address the asks of this resolution. There were a number of
28 proposed amendments seeking to expand the scope beyond older adults to include other
29 populations at high risk of suicide, including younger adults, LGBTQ+ individuals, BIPOC
30 individuals and persons living with disabilities. Rather than listing all groups, your Reference
31 Committee thought it was most appropriate to reference high risk populations to ensure
32 inclusivity. Therefore, your Reference Committee recommends that existing policy D-345.974
33 be adopted as amended.
34

35 (10) RESOLUTION 909 – DECREASING GUN VIOLENCE
36 AND SUICIDE IN SENIORS
37

38 **RECOMMENDATION A:**

39
40 That the first Resolve of Resolution 909 be amended by
41 addition and deletion to read as follows:
42

43 RESOLVED, That our American Medical Association and
44 other organizations develop and disseminate a formal
45 educational program to enable clinicians to effectively and
46 efficiently address suicides with an emphasis on seniors and
47 other high-risk populations ~~firearms~~ (Directive to Take
48 Action); and be it further

1 **RECOMMENDATION B:**

2
3 That the third Resolve of Resolution 909 be amended by
4 addition and deletion to read as follows:

5
6 RESOLVED, That our AMA partner with other groups
7 interested in firearm safety to raise public awareness of the
8 magnitude of suicide in seniors and other high-risk
9 populations, and interventions available for suicide
10 prevention regarding ~~senior suicides and firearms.~~
11 (Directive to Take Action)

12
13 **RECOMMENDATION C:**

14
15 Resolution 909 be adopted as amended.

16
17 **RECOMMENDATION D:**

18
19 That the title of Resolution 909 be changed to read as
20 follows:

21 DECREASING FIREARM VIOLENCE AND SUICIDE IN
22 SENIORS AND OTHER HIGH-RISK POPULATIONS

23
24 **HOD ACTION: Resolution 909 adopted as amended**
25 **with a change in title to read as follows:**

26
27 DECREASING FIREARM VIOLENCE AND SUICIDE IN
28 SENIORS AND OTHER HIGH-RISK POPULATIONS

29
30 RESOLVED, That our American Medical Association and other organizations develop and
31 disseminate a formal educational program to enable clinicians to effectively and efficiently
32 address suicides with an emphasis on seniors and firearms (Directive to Take Action); and be
33 it further

34
35 RESOLVED, That our AMA develop with other interested organizations a toolkit for clinicians
36 to use addressing Extreme Risk Protection Orders in their individual states (Directive to Take
37 Action); and be it further

38
39 RESOLVED, That our AMA partner with other groups interested in firearm safety to raise
40 public awareness of magnitude and interventions available regarding senior suicides and
41 firearms. (Directive to Take Action)

42
43 Your Reference Committee heard testimony in strong support of this resolution and on the
44 importance of increasing awareness and education around older adults being a high-risk
45 group for firearm injury and death. Amendments were proffered to expand the resolution to
46 include other high-risk groups such as LGBTQ+ individuals, veterans, Black, Indigenous,
47 other people of color, and those living with disabilities. Your Reference Committee agrees that
48 it is worth expanding the resolution to be inclusive of other high-risk populations.

1 It was noted in testimony that our AMA has an existing CME module on the “Physicians Role
2 in Firearm Safety” that addresses how clinicians can effectively address patients at high-risk
3 of injury and death from firearms, including suicides. That module is currently being updated
4 to reflect current data and evidence-based practices. Our AMA has also developed a CME
5 module on “Identifying and Responding to Suicide Risk” at the direction of this House of
6 Delegates. Our AMA is also in the final stages of developing a state-by-state legal resources
7 to guide physician decision-making on firearm safety, including information on extreme risk
8 protection orders by jurisdiction. It is anticipated this resource will be available in early 2023.
9 Therefore, your Reference Committee recommends that Resolution 909 be adopted as
10 amended.

11
12 (11) RESOLUTION 910 – GONAD SHIELDS: REGULATORY
13 AND LEGISLATION ADVOCACY TO OPPOSE ROUTINE
14 USE

15
16 **RECOMMENDATION A:**

17
18 The first Resolve of Resolution 910 be amended by addition
19 to read as follows:

20
21 RESOLVED, That our American Medical Association
22 oppose mandatory use of patient gonad shields in medical
23 imaging, considering the risks far outweigh the benefits
24 (New HOD Policy); and be it further

25
26 **RECOMMENDATION B:**

27
28 The second Resolve of Resolution 910 be amended by
29 addition to read as follows:

30
31 RESOLVED, That our AMA advocate that the U.S. Food
32 and Drug Administration amend the code of federal
33 regulations to oppose the routine use of patient gonad
34 shields in medical imaging (Directive to Take Action); and
35 be it further

36
37 **RECOMMENDATION C:**

38
39 The third Resolve of Resolution 910 be amended by
40 addition to read as follows:

41
42 RESOLVED, That our AMA, in conjunction with state
43 medical societies, support model state and national
44 legislation to oppose or repeal mandatory use of patient
45 gonad shields in medical imaging (New HOD Policy)

46
47 **RECOMMENDATION D:**

48
49 Resolution 910 be adopted as amended.

50
51 **HOD ACTION: Resolution 910 adopted as amended.**

1 RESOLVED, That our American Medical Association oppose mandatory use of gonad shields
2 in medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be
3 it further

4
5 RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the
6 code of federal regulations to oppose the routine use of gonad shields in medical imaging
7 (Directive to Take Action); and be it further

8
9 RESOLVED, That our AMA, in conjunction with state medical societies, support model state
10 and national legislation to oppose or repeal mandatory use of gonad shields in medical
11 imaging (New HOD Policy)

12
13 Your Reference Committee heard unanimously supportive testimony for removing mandates
14 for the use of gonad shielding during radiological imaging. Those testifying noted that recent
15 literature findings and improvements in medical imaging technology have changed the
16 balance of risk and benefit when using a gonad shield in a pediatric patient. One speaker
17 noted that as written, the resolution could be interpreted to infer that personal protective
18 equipment for health care professionals was no longer being recommended, and an
19 amendment to clarify the scope was proffered. Your Reference Committee agrees that this
20 amendment is an important clarification and recommends that the resolution be adopted as
21 amended.

22
23 (12) RESOLUTION 915 – PULSE OXIMETRY IN PATIENTS
24 WITH PIGMENTED SKIN

25
26 **RECOMMENDATION A:**

27
28 Resolution 915 be amended by addition and deletion to read
29 as follows:

30
31 RESOLVED, That our American Medical Association
32 recognizes that pulse oximeters may not accurately
33 measure oxygen saturation in all skin tones and will
34 continue to urge make recommendations to the US Food
35 and Drug Administration that will to (1) ensure pulse
36 oximeters provide accurate and reliable readings for
37 patients with diverse degrees of skin pigmentation and (2)
38 ensure health care personnel and the public are educated
39 on the limitations of pulse oximeter technology so they can
40 account for measurement error. (Directive to Take Action)

41
42 **RECOMMENDATION B:**

43
44 Resolution 915 be adopted as amended.

45
46 **HOD ACTION: Resolution 915 adopted as amended.**

47
48 RESOLVED, That our American Medical Association make recommendations to the US Food
49 and Drug Administration that will ensure pulse oximeters provide accurate and reliable
50 readings for patients with diverse degrees of skin pigmentation. (Directive to Take Action)

1 Testimony was heard in support of this resolution and the authors were commended for
2 identifying both the source of inequities and a path forward to alleviate it. Your Reference
3 Committee heard testimony noting that our AMA recently participated in an FDA convening
4 on this issue and called on the FDA to ensure the accuracy and reliability of pulse oximetry
5 readings in patients with diverse degrees of skin pigmentation. We are proposing
6 amendments for adoption to clarify the ask for our AMA to continue to urge the FDA to address
7 this issue and help ensure health care personnel and the public are aware of the limitations
8 of this technology so they can account for measurement error.

9
10 (13) RESOLUTION 916 – NON-CERVICAL HPV ASSOCIATED
11 CANCER PREVENTION

12
13 **RECOMMENDATION A:**

14
15 Resolution 916 be amended by addition and deletion to read as
16 follows:

17
18 RESOLVED, That our American Medical Association amend
19 policy H-440.872, “HPV Vaccine and Cervical Cancer
20 Prevention Worldwide,” by addition and deletion to read as
21 follows:

22
23 HPV Vaccine and Cervical Cancer Prevention Worldwide, H-
24 440.872

25 1. Our AMA (a) urges physicians to educate themselves and
26 their patients about HPV and associated diseases, HPV
27 vaccination, as well as routine ~~cervical~~ HPV related cancer
28 screening ~~for those at risk~~; and (b) encourages the development
29 and funding of programs targeted at HPV vaccine introduction
30 and ~~cervical~~ HPV related cancer screening in countries without
31 organized ~~cervical~~ HPV related cancer screening programs.

32 2. Our AMA will intensify efforts to improve awareness and
33 understanding about HPV and associated diseases, in all
34 individuals, regardless of sex, such as, but not limited to,
35 cervical cancer, head and neck cancer, anal cancer, and penile
36 genital cancer, the availability and efficacy of HPV vaccinations,
37 and the need for routine ~~cervical~~ HPV related cancer screening
38 in the general public.

39 3. Our AMA:

40 (a) encourages the integration of HPV vaccination and routine
41 cervical cancer screening into all appropriate health care
42 settings and visits ~~for adolescents and young adults~~,

43 (b) supports the availability of the HPV vaccine and routine
44 cervical cancer screening to appropriate patient groups that
45 benefit most from preventive measures, including but not limited
46 to low-income and pre-sexually active populations,

47 (c) recommends HPV vaccination for all groups for whom the
48 federal Advisory Committee on Immunization Practices
49 recommends HPV vaccination.

50 4. Our AMA encourage appropriate stakeholders to investigate
51 means to increase HPV vaccination rates by:

1 a. facilitating administration of HPV vaccinations in community-
2 based settings including school settings, and
3 b. supporting state mandates for HPV vaccination for school
4 attendance. (Modify Current HOD Policy);

5
6 RESOLVED, That our AMA study requiring HPV vaccination for
7 school attendance (Directive to Take Action).

8
9 **RECOMMENDATION B:**

10
11 Resolution 916 be adopted as amended.

12
13 **RECOMMENDATION C:**

14
15 That the title of Resolution 916 be changed to read as
16 follows:

17
18 HPV-ASSOCIATED CANCER PREVENTION

19
20 **HOD ACTION: Resolution 916 adopted as amended**
21 **with a change in title to read as follows:**

22
23 HPV-ASSOCIATED CANCER PREVENTION

24
25 RESOLVED, That our American Medical Association amend policy H-440.872, "HPV Vaccine
26 and Cervical Cancer Prevention Worldwide," by addition and deletion to read as follows:

27
28 HPV Vaccine and Cervical Cancer Prevention Worldwide, H-440.872

29 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and
30 associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those
31 at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine
32 introduction and cervical cancer screening in countries without organized cervical cancer
33 screening programs.

34 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and
35 associated diseases, in all individuals regardless of sex, such as, but not limited to, cervical
36 cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of
37 HPV vaccinations, and the need for routine cervical cancer screening in the general public.

38 3. Our AMA:

39 (a) encourages the integration of HPV vaccination and routine cervical cancer screening into
40 all appropriate health care settings and visits ~~for adolescents and young adults,~~

41 (b) supports the availability of the HPV vaccine and routine cervical cancer screening to
42 appropriate patient groups that benefit most from preventive measures, including but not
43 limited to low-income and pre-sexually active populations,

44 (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on
45 Immunization Practices recommends HPV vaccination.

46 4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV
47 vaccination rates by:

48 a. facilitating administration of HPV vaccinations in community-based settings including
49 school settings, and

50 b. supporting state mandates for HPV vaccination for school attendance. (Modify Current HOD
51 Policy); and be it further

1
2 RESOLVED, That our AMA support legislation and funding for research aimed towards
3 discovering screening methodology and early detection methods for other non-cervical HPV
4 associated cancers.

5
6 Your Reference Committee heard testimony that was broadly supportive, indicating that the
7 current focus on cervical cancer for HPV vaccinations has led to mistakenly excluding people
8 at risk for HPV-related cancers at other sites that would benefit from its protection. It was
9 further noted that HPV is commonly thought of in relation to cervical cancer, neglecting other
10 non-cervical cancers such as head, neck, vulvar, and genital cancer, which affect people
11 regardless of gender. Broadly, those who testified supported this resolution, with the exception
12 of the mandate for HPV vaccinations for school attendance. While it is was recognized that
13 early immunization with the HPV vaccination provides high efficacy for cancer prevention,
14 there was concern expressed about expanding school vaccine mandates. Your Reference
15 Committee agrees. Therefore, your Reference Committee recommends that Resolution 916
16 be adopted as amended.

17
18 (14) RESOLUTION 919 – DECREASING YOUTH ACCESS TO
19 E-CIGARETTES

20
21 **RECOMMENDATION A:**

22
23 That the second Resolve of Resolution 919 be amended by
24 addition and deletion to read as follows:

25
26 RESOLVED, That AMA policy H-495.986, "Tobacco
27 Product Sales and Distribution," be amended by addition to
28 read as follows:

29
30 Tobacco Product Sales and Distribution, H-495.986

31 Our AMA:

32 (1) recognizes the use of e-cigarettes and vaping as an
33 urgent public health epidemic and will actively work with the
34 Food and Drug Administration and other relevant
35 stakeholders to counteract the marketing and use of
36 addictive e-cigarette and vaping devices, including but not
37 limited to bans and strict restrictions on marketing to minors
38 under the age of 21;

39 (2) encourages the passage of laws, ordinances and
40 regulations that would set the minimum age for purchasing
41 tobacco products, including electronic nicotine delivery
42 systems (ENDS) and e-cigarettes, at 21 years, and urges
43 strict enforcement of laws prohibiting the sale of tobacco
44 products to minors;

45 (3) supports the development of model legislation regarding
46 enforcement of laws restricting children's access to tobacco,
47 including but not limited to attention to the following issues:

48 (a) provision for licensure to sell tobacco and for the
49 revocation thereof; (b) appropriate civil or criminal penalties
50 (e.g., fines, prison terms, license revocation) to deter
51 violation of laws restricting children's access to and

1 possession of tobacco; (c) requirements for merchants to
2 post notices warning minors against attempting to purchase
3 tobacco and to obtain proof of age for would-be purchasers;
4 (d) measures to facilitate enforcement; (e) banning out-of-
5 package cigarette sales ("loosies"); and (f) requiring tobacco
6 purchasers and vendors to be of legal smoking age;
7 (4) requests that states adequately fund the enforcement of
8 the laws related to tobacco sales to minors;
9 (5) opposes the use of vending machines to distribute
10 tobacco products and supports ordinances and legislation
11 to ban the use of vending machines for distribution of
12 tobacco products;
13 (6) seeks a ban on the production, distribution, and sale of
14 candy products that depict or resemble tobacco products;
15 (7) opposes the distribution of free tobacco products by any
16 means and supports the enactment of legislation prohibiting
17 the disbursement of samples of tobacco and tobacco
18 products by mail;
19 (8) (a) publicly commends (and so urges local medical
20 societies) pharmacies and pharmacy owners who have
21 chosen not to sell tobacco products, and asks its members
22 to encourage patients to seek out and patronize pharmacies
23 that do not sell tobacco products; (b) encourages other
24 pharmacists and pharmacy owners individually and through
25 their professional associations to remove such products
26 from their stores; (c) urges the American Pharmacists
27 Association, the National Association of Retail Druggists,
28 and other pharmaceutical associations to adopt a position
29 calling for their members to remove tobacco products from
30 their stores; and (d) encourages state medical associations
31 to develop lists of pharmacies that have voluntarily banned
32 the sale of tobacco for distribution to their members; ~~and~~
33 (9) opposes the sale of tobacco at any facility where health
34 services are provided; ~~and~~
35 (10) supports that the sale of tobacco products be restricted
36 to tobacco specialty stores; ~~and~~
37 ~~(11) supports measures that prevent retailers from opening~~
38 ~~new tobacco specialty stores in proximity to elementary~~
39 ~~schools, middle schools, and high schools; ~~and~~~~
40 ~~(12) support measures that decrease the overall density of~~
41 ~~tobacco specialty stores, including but not limited to,~~
42 ~~preventing retailers from opening new tobacco specialty~~
43 ~~stores in proximity to existing tobacco specialty stores.~~
44 (Modify Current HOD Policy)

45
46 **RECOMMENDATION B:**

47
48 Resolution 919 be adopted as amended.

49
50 **HOD ACTION: Resolution 919 be referred.**

51

1 RESOLVED, That our American Medical Association support the inclusion of disposable and
2 tank-based e-cigarettes in the language and implementation of any restrictions that are
3 applied by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes
4 (New HOD Policy); and be it further

5
6 RESOLVED, That AMA policy H-495.986, "Tobacco Product Sales and Distribution," be
7 amended by addition to read as follows:

8
9 **Tobacco Product Sales and Distribution, H-495.986**

10 Our AMA:

11 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will
12 actively work with the Food and Drug Administration and other relevant stakeholders to
13 counteract the marketing and use of addictive e-cigarette and vaping devices, including but
14 not limited to bans and strict restrictions on marketing to minors under the age of 21;

15 (2) encourages the passage of laws, ordinances and regulations that would set the minimum
16 age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS)
17 and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of
18 tobacco products to minors;

19 (3) supports the development of model legislation regarding enforcement of laws restricting
20 children's access to tobacco, including but not limited to attention to the following issues: (a)
21 provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or
22 criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws
23 restricting children's access to and possession of tobacco; (c) requirements for merchants to
24 post notices warning minors against attempting to purchase tobacco and to obtain proof of
25 age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-
26 package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of
27 legal smoking age;

28 (4) requests that states adequately fund the enforcement of the laws related to tobacco sales
29 to minors;

30 (5) opposes the use of vending machines to distribute tobacco products and supports
31 ordinances and legislation to ban the use of vending machines for distribution of tobacco
32 products;

33 (6) seeks a ban on the production, distribution, and sale of candy products that depict or
34 resemble tobacco products;

35 (7) opposes the distribution of free tobacco products by any means and supports the
36 enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco
37 products by mail;

38 (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy
39 owners who have chosen not to sell tobacco products, and asks its members to encourage
40 patients to seek out and patronize pharmacies that do not sell tobacco products; (b)
41 encourages other pharmacists and pharmacy owners individually and through their
42 professional associations to remove such products from their stores; (c) urges the American
43 Pharmacists Association, the National Association of Retail Druggists, and other
44 pharmaceutical associations to adopt a position calling for their members to remove tobacco
45 products from their stores; and (d) encourages state medical associations to develop lists of
46 pharmacies that have voluntarily banned the sale of tobacco for distribution to their members;
47 and (9) opposes the sale of tobacco at any facility where health services are provided; and
48 (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

49 (11) supports measures that prevent retailers from opening new tobacco specialty stores in
50 proximity to elementary schools, middle schools, and high schools; and

1 (12) support measures that decrease the overall density of tobacco specialty stores, including
2 but not limited to, preventing retailers from opening new tobacco specialty stores in proximity
3 to existing tobacco specialty stores. (Modify Current HOD Policy)
4

5 Your Reference Committee heard testimony unanimously in support of Resolution 919. The
6 speakers affirmed the dangers of nicotine, particularly in youths, and the utility of this
7 resolution to distance retailers from schools. Speakers recommended the removal of the
8 twelfth item due to restriction of free commerce capabilities. Therefore, your Reference
9 Committee recommends that Resolution 919 be adopted as amended.

10
11 (15) RESOLUTION 921 – FIREARM INJURY AND DEATH
12 RESEARCH AND PREVENTION

13
14 **RECOMMENDATION A:**

15
16 Policy D-145.999, “Epidemiology of Firearm Injuries” be
17 amended by addition in lieu of the first Resolve of Resolution
18 921.
19

20 Our AMA will: (1) strongly urge the Administration and
21 Congress to encourage the Centers for Disease Control and
22 Prevention to conduct an epidemiological analysis of the
23 data of firearm-related injuries and deaths; ~~and~~ (2) urge
24 Congress to provide sufficient resources to enable the CDC
25 to collect and analyze firearm-related injury data and report
26 to Congress and the nation via a broadly disseminated
27 document, so that physicians and other health care
28 providers, law enforcement and society at large may be able
29 to prevent injury, death and the other costs to society
30 resulting from firearms, and (3) advocate for improvements
31 to the quality, comparability, and timeliness of data on
32 firearm injuries and deaths.
33

34 **RECOMMENDATION B:**

35
36 The second Resolve of Resolution 921 be amended by
37 addition and deletion to read as follows:
38

39 RESOLVED, That our AMA advocate for repeal of laws the
40 2003 Tiahrt amendment which prohibits the release of
41 firearm tracing data for research (Directive to Take Action);
42

43 **RECOMMENDATION C:**

44
45 That Policies D-145.994, “Removing Restrictions on
46 Federal Funding for Firearm Violence Research,” D-
47 145.995, “Gun Violence as a Public Health Crisis,” and H-
48 145.997, “Firearms as a Public Health Problem in the United
49 States - Injuries and Death” be reaffirmed in lieu of the third
50 Resolve.

1 **RECOMMENDATION D:**

2
3 Resolution 921 be adopted as amended.

4
5 **HOD ACTION: Resolution 921 adopted as amended.**

6
7 **That Policies D-145.994, “Removing Restrictions on**
8 **Federal Funding for Firearm Violence Research,” D-**
9 **145.995, “Gun Violence as a Public Health Crisis,”**
10 **and H-145.997, “Firearms as a Public Health**
11 **Problem in the United States - Injuries and Death”**
12 **reaffirmed in lieu of the third Resolve.**

13
14 RESOLVED, That our American Medical Association and all interested medical societies
15 advocate for a comprehensive national-level data system for firearm injuries and deaths
16 including real-time surveillance and continued improvements to the quality and comparability
17 of currently collected data (Directive to Take Action); and be it further

18
19 RESOLVED, That our AMA advocate for repeal of the 2003 Tiahrt amendment which prohibits
20 the release of firearm tracing data for research (Directive to Take Action); and be it further

21
22 RESOLVED, That our AMA advocate for additional federal budgetary funding for expanded
23 firearm injury and death prevention research at all appropriate federal agencies in order to
24 better understand the risk and protective factors for firearm injuries and to develop evidence-
25 based interventions at the individual, house-hold, community, state, and federal levels to
26 decrease firearm injuries and deaths. (Directive to Take Action)

27
28 Your Reference Committee heard testimony in support of this resolution. It was noted in
29 testimony that there is extensive AMA policy addressing both the first and third Resolve
30 statements. Your Reference Committee proposed amendments to existing policy on firearm
31 epidemiology to incorporate calls for improvements in the timeliness and quality of the data.
32 The second Resolve is not addressed in existing AMA policy, but your Reference Committee
33 proposes removing reference to the “2003 Tiahrt amendment.” Your Reference Committee
34 also proposes reaffirming existing AMA policy on funding firearm research in lieu of the third
35 Resolve. Therefore, your Reference Committee recommends that Resolution 921 be adopted
36 as amended.

37
38 Policies recommended for reaffirmation:

39
40 D-145.994 Removing Restrictions on Federal Funding for Firearm Violence Research
41 Our AMA will provide an informational report on recent and current organizational
42 actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the
43 restrictions on federal funding for firearms violence research, with additional
44 recommendations on any ongoing or proposed upcoming actions.

45
46 D-145.995 Gun Violence as a Public Health Crisis

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

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

3 1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially
4 handguns, is a serious threat to the public's health inasmuch as the weapons are one
5 of the main causes of intentional and unintentional injuries and deaths.
6

7 Therefore, the AMA:

8 (A) encourages and endorses the development and presentation of safety education
9 programs that will engender more responsible use and storage of firearms;

10 (B) urges that government agencies, the CDC in particular, enlarge their efforts in the
11 study of firearm-related injuries and in the development of ways and means of reducing
12 such injuries and deaths;

13 (C) urges Congress to enact needed legislation to regulate more effectively the
14 importation and interstate traffic of all handguns;

15 (D) urges the Congress to support recent legislative efforts to ban the manufacture
16 and importation of nonmetallic, not readily detectable weapons, which also resemble
17 toy guns; (5) encourages the improvement or modification of firearms so as to make
18 them as safe as humanly possible;

19 (E) encourages nongovernmental organizations to develop and test new, less
20 hazardous designs for firearms;

21 (F) urges that a significant portion of any funds recovered from firearms manufacturers
22 and dealers through legal proceedings be used for gun safety education and gun-
23 violence prevention; and

24 (G) strongly urges US legislators to fund further research into the epidemiology of risks
25 related to gun violence on a national level.
26

27 2. Our AMA will advocate for firearm safety features, including but not limited to
28 mechanical or smart technology, to reduce accidental discharge of a firearm or
29 misappropriation of the weapon by a non-registered user; and support legislation and
30 regulation to standardize the use of these firearm safety features on weapons sold for
31 non-military and non-peace officer use within the U.S.; with the aim of establishing
32 manufacturer liability for the absence of safety features on newly manufactured
33 firearms.
34

35 (16) RESOLUTION 924 – DOMESTIC PRODUCTION OF
36 PERSONAL PROTECTIVE EQUIPMENT
37

38 **RECOMMENDATION A:**
39

40 That the first Resolve of Resolution 924 be amended by
41 addition and deletion to read as follows:
42

43 RESOLVED, That our American Medical Association
44 ~~support~~ encourage state and federal ~~incentives~~ efforts to
45 locate the manufacturing of goods used in healthcare and
46 healthcare facilities in the United States (New HOD Policy);
47

48 **RECOMMENDATION B:**
49

50 That the second Resolve of Resolution 924 be amended by
51 deletion to read as follows:

1
2 RESOLVED, That our AMA support federal the efforts of the
3 Administration and CMS to encourage the purchase of
4 domestically produced personal protective equipment_(New
5 HOD Policy)
6

7 **RECOMMENDATION C:**

8
9 Resolution 924 be adopted as amended.

10
11 **HOD ACTION: Resolution 924 adopted as amended.**

12
13 RESOLVED, That our American Medical Association support state and federal incentives to
14 locate the manufacturing of goods used in healthcare and healthcare facilities in the United
15 States (New HOD Policy); and be it further

16
17 RESOLVED, That our AMA support the efforts of the Administration and CMS to encourage
18 the purchase of domestically produced personal protective equipment (New HOD Policy); and
19 be it further

20
21 RESOLVED, That our AMA reaffirm policy H-440.847, "Pandemic Preparedness." (Reaffirm
22 HOD Policy)
23

24 Your Reference Committee heard testimony in support of this resolution, particularly in the
25 wake of the severe personal protective equipment (PPE) shortages experienced by frontline
26 health care personnel during the COVID-19 pandemic. In particular, speakers testified that
27 PPE shortages should be categorized as a "never" event, and that domestic production is one
28 of the preferred methods for guaranteeing that domestic health care workers have access to
29 supplies when global demand is at its highest. Amendments were offered to expand the scope
30 to any strategy that may increase production, not just financial incentives. Similarly,
31 amendments were offered which would preserve the intent of the resolution even as priorities
32 of the administration will likely change over time. Your Reference Committee agrees that these
33 amendments make the resolution more flexible in achieving its goal, and therefore
34 recommends that this resolution be adopted as amended.
35

36 (17) RESOLUTION 928 – EXPANDING TRANSPLANT
37 EVALUATION CRITERIA TO INCLUDE PATIENTS THAT
38 MAY NOT SATISFY CENTER-SPECIFIC ALCOHOL
39 SOBRIETY REQUIREMENTS
40

41 **RECOMMENDATION A:**

42
43 Resolution 928 be amended by addition and deletion to read
44 as follows:

45
46 RESOLVED, That our American Medical Association
47 encourage transplant centers to consider evaluation of
48 ~~expand potential recipient evaluation criteria to include~~
49 ~~patients that~~ who may not satisfy center-specific alcohol
50 sobriety requirements on a case-by-case basis, using

1 medically appropriate criteria ~~supportable by peer-reviewed~~
2 ~~and published research.~~ (New HOD Policy)

3
4 **RECOMMENDATION B:**

5
6 Resolution 928 be adopted as amended.

7
8 **RECOMMENDATION C:**

9
10 That the title of Resolution 928 be changed to read as
11 follows:

12
13 EXPANDING TRANSPLANT EVALUATION CRITERIA TO
14 INCLUDE PATIENTS THAT MAY NOT SATISFY CENTER-
15 SPECIFIC SOBRIETY REQUIREMENTS

16
17 **HOD ACTION: Resolution 928 adopted as amended**
18 **with a change in title to read as follows:**

19
20 EXPANDING TRANSPLANT EVALUATION CRITERIA
21 TO INCLUDE PATIENTS THAT MAY NOT SATISFY
22 CENTER-SPECIFIC SOBRIETY REQUIREMENTS

23
24 **RESOLVED**, That our American Medical Association encourage transplant centers to expand
25 potential recipient evaluation criteria to include patients that may not satisfy center-specific
26 alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria
27 supportable by peer-reviewed and published research. (New HOD Policy)

28
29 Testimony on this resolution was supportive of the intent of increasing physician judgement
30 and a more holistic risk assessment for transplant eligibility criteria. Some who testified before
31 your Reference Committee noted personal experience with liver transplants and sought
32 clarification over the usage of the term “donor” and “recipient.” In their experience, it was
33 critical that the recipient abstain from alcohol consumption to maximize the likelihood of
34 successful transplants. Testimony provided in support noted strict sobriety requirements could
35 be actively harming patients and do not have a significant impact on relapse rates for liver
36 transplant recipients. Additional testimony noted that while much of the discussion focused on
37 liver transplants and abstention from alcohol, other organ transplants may have similarly
38 restrictive criteria related to other substance use that is not borne from evidence. Therefore,
39 your Reference Committee recommends that Resolution 928 be adopted as amended.

40
41 (18) RESOLUTION 929 – OPPOSING THE MARKETING OF
42 PHARMACEUTICALS TO PARTIES RESPONSIBLE FOR
43 CAPTIVE POPULATIONS

44
45 **RECOMMENDATION A:**

46
47 That the first Resolve of Resolution 929 be amended by
48 deletion to read as follows:

49
50 RESOLVED, That our American Medical Association
51 oppose the practice of pharmaceutical marketing towards

1 those who make decisions for captive populations;
2 including, but not limited to, doctors working in a correctional
3 capacity, judges, wardens, sheriffs, correctional officers,
4 Immigration and Customs Enforcement, and other detention
5 administrators; (New HOD Policy)
6

7 **RECOMMENDATION B:**

8
9 That the second Resolve of Resolution 929 be amended by
10 addition and deletion to read as follows:

11
12 RESOLVED, That our AMA advocate for the inclusion of
13 physicians and pharmacists in the selection of medications
14 available to ~~vulnerable populations~~ captive populations,
15 such as incarcerated individuals (Directive to Take Action)
16

17 **RECOMMENDATION C:**

18
19 Resolution 929 be adopted as amended.

20
21 **HOD ACTION: Resolution 929 adopted as amended.**

22
23 RESOLVED, That our American Medical Association oppose the practice of pharmaceutical
24 marketing towards those who make decisions for captive populations, including, but not
25 limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional
26 officers, Immigration and Customs Enforcement, and other detention administrators (New
27 HOD Policy); and be it further

28
29 RESOLVED, That our AMA advocate for the inclusion of physicians in the selection of
30 medications available to vulnerable populations such as incarcerated individuals (Directive to
31 Take Action); and be it further

32
33 RESOLVED, That our AMA support and work with state medical societies to support
34 measures to increase transparency in medication procurement, including but not limited to:
35 (1) requiring those responsible for medical procurement to report gifts from pharmaceutical
36 companies over a minimum amount; and (2) centralizing formulary choices in a physician-led
37 office, agency, or commission following the principles of a sound formulary. (New HOD Policy)
38

39 Your Reference Committee heard testimony reflecting the complexities of providing care for
40 captive populations in the correctional system, and how dramatically care can vary from
41 federal, state, and county systems. Many testified to the implicit bias that pharmaceutical
42 advertising or gifts to clinicians of captive populations can have, even if the physician is acting
43 with integrity and exercising strict adherence to an ethical code. In addition, several speakers
44 testified to concerns over non-physician decision makers that may be included in the
45 contracting of medication formularies who may not uphold the same rigorous ethical standards
46 as physicians, and utility of pharmacists to support evidence-based formulary decision-
47 making. Amendments were offered to remove specific reference to individuals or professions
48 involved in pharmaceutical decision-making to alleviate concerns that the resolution may be
49 inadvertently excluding people involved in the process. Therefore, your Reference Committee
50 recommends that this resolution be adopted as amended.

1 (19) RESOLUTION 931 – AMENDING H-160.903
2 ERADICATING HOMELESSNESS TO INCLUDE
3 SUPPORT FOR STREET MEDICINE PROGRAMS
4

5 **RECOMMENDATION A:**
6

7 That the first Resolve of Resolution 931 be amended by
8 addition and deletion to read as follows:
9

10 RESOLVED, That our American Medical Association
11 encourage medical schools to implement physician-led,
12 team-based Street Medicine programs ~~and/or promote~~
13 ~~student led Street Medicine programs~~ with student
14 involvement. (New HOD Policy)
15

16 **RECOMMENDATION B:**
17

18 That the second Resolve of Resolution 931 be amended by
19 addition and deletion to read as follows:
20

21 RESOLVED, That our AMA recognizes and supports the
22 use of Street Medicine programs by amending policy H-
23 160.903 Eradicating Homelessness by addition and deletion
24 to read as follows:
25

26 Eradicating Homelessness, H-160.903 Our AMA:

27 (1) supports improving the health outcomes and decreasing
28 the health care costs of treating the chronically homeless
29 through clinically proven, high quality, and cost effective
30 approaches which recognize the positive impact of stable
31 and affordable housing coupled with social services;

32 (2) recognizes that stable, affordable housing as a first
33 priority, without mandated therapy or services compliance,
34 is effective in improving housing stability and quality of life
35 among individuals who are chronically-homeless;

36 (3) recognizes adaptive strategies based on regional
37 variations, community characteristics and state and local
38 resources are necessary to address this societal problem on
39 a long-term basis;

40 (4) supports the use of physician-led, team-based street
41 medicine programs, which travel to individuals who are
42 unhoused or unsheltered and provide healthcare and social
43 services, as well as funds, including Medicaid and other
44 public insurance reimbursement, for their maintenance;

45 (45) recognizes the need for an effective, evidence-based
46 national plan to eradicate homelessness;

47 (56) encourages the National Health Care for the Homeless
48 Council to study the funding, implementation, and
49 standardized evaluation of Medical Respite Care for
50 homeless persons;

1 (67) will partner with relevant stakeholders to educate
2 physicians about the unique healthcare and social needs of
3 homeless patients and the importance of holistic, cost-
4 effective, evidence-based discharge planning, and
5 physicians' role therein, in addressing these needs;
6 (78) encourages the development of holistic, cost-effective,
7 evidence-based discharge plans for homeless patients who
8 present to the emergency department but are not admitted
9 to the hospital;
10 (89) encourages the collaborative efforts of communities,
11 physicians, hospitals, health systems, insurers, social
12 service organizations, government, and other stakeholders
13 to develop comprehensive homelessness policies and plans
14 that address the healthcare and social needs of homeless
15 patients;
16 (910) (a) supports laws protecting the civil and human rights
17 of individuals experiencing homelessness, and (b) opposes
18 laws and policies that criminalize individuals experiencing
19 homelessness for carrying out life-sustaining activities
20 conducted in public spaces that would otherwise be
21 considered non-criminal activity (i.e., eating, sitting, or
22 sleeping) when there is no alternative private space
23 available; and
24 (4011) recognizes that stable, affordable housing is
25 essential to the health of individuals, families, and
26 communities, and supports policies that preserve and
27 expand affordable housing across all neighborhoods; and
28 (4412) (a) supports training to understand the needs of
29 housing insecure individuals for those who encounter this
30 vulnerable population through their professional duties; (b)
31 supports the establishment of multidisciplinary mobile
32 homeless outreach teams trained in issues specific to
33 housing insecure individuals; and (c) will make available
34 existing educational resources from federal agencies and
35 other stakeholders related to the needs of housing-insecure
36 individuals; and
37 ~~(13) supports federal and state efforts to enact just cause~~
38 ~~eviction statutes and examine and restructure punitive~~
39 ~~eviction practices; instate inflation-based rent control;~~
40 ~~guarantee tenants' right to counsel in housing disputes and~~
41 ~~improve affordability of legal fees; and create national, state,~~
42 ~~and/or local rental registries.~~ (Modify Current HOD Policy)

44 RECOMMENDATION C:

45
46 Resolution 931 be adopted as amended.

47
48 **HOD ACTION: Resolution 931 adopted as amended.**

1 RESOLVED, That our American Medical Association encourage medical schools to
2 implement Street Medicine programs and/or promote student-led Street Medicine programs
3 (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA recognizes and supports the use of Street Medicine programs by
6 amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as
7 follows:

8 Eradicating Homelessness, H-160.903 Our AMA:

9 (1) supports improving the health outcomes and decreasing the health care costs of treating
10 the chronically homeless through clinically proven, high quality, and cost effective approaches
11 which recognize the positive impact of stable and affordable housing coupled with social
12 services;

13 (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or
14 services compliance, is effective in improving housing stability and quality of life among
15 individuals who are chronically-homeless;

16 (3) recognizes adaptive strategies based on regional variations, community characteristics
17 and state and local resources are necessary to address this societal problem on a long-term
18 basis;

19 (4) supports the use of street medicine programs, which travel to individuals who are
20 unhoused or unsheltered and provide healthcare and social services, as well as funds,
21 including Medicaid and other public insurance reimbursement, for their maintenance;

22 (45) recognizes the need for an effective, evidence-based national plan to eradicate
23 homelessness;

24 (56) encourages the National Health Care for the Homeless Council to study the funding,
25 implementation, and standardized evaluation of Medical Respite Care for homeless persons;

26 (67) will partner with relevant stakeholders to educate physicians about the unique healthcare
27 and social needs of homeless patients and the importance of holistic, cost-effective, evidence-
28 based discharge planning, and physicians' role therein, in addressing these needs;

29 (78) encourages the development of holistic, cost-effective, evidence-based discharge plans
30 for homeless patients who present to the emergency department but are not admitted to the
31 hospital;

32 (89) encourages the collaborative efforts of communities, physicians, hospitals, health
33 systems, insurers, social service organizations, government, and other stakeholders to
34 develop comprehensive homelessness policies and plans that address the healthcare and
35 social needs of homeless patients;

36 (910) (a) supports laws protecting the civil and human rights of individuals experiencing
37 homelessness, and (b) opposes laws and policies that criminalize individuals experiencing
38 homelessness for carrying out life-sustaining activities conducted in public spaces that would
39 otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is
40 no alternative private space available; and

41 (4011) recognizes that stable, affordable housing is essential to the health of individuals,
42 families, and communities, and supports policies that preserve and expand affordable housing
43 across all neighborhoods; and

44 (4412) (a) supports training to understand the needs of housing insecure individuals for those
45 who encounter this vulnerable population through their professional duties; (b) supports the
46 establishment of multidisciplinary mobile homeless outreach teams trained in issues specific
47 to housing insecure individuals; and (c) will make available existing educational resources
48 from federal agencies and other stakeholders related to the needs of housing-insecure
49 individuals; and

50 (13) supports federal and state efforts to enact just cause eviction statutes and examine and
51 restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants'

1 right to counsel in housing disputes and improve affordability of legal fees; and create national,
2 state, and/or local rental registries. (Modify Current HOD Policy)
3

4 Your Reference Committee heard testimony in support of this resolution. Multiple commentors
5 noted the importance of street medicine teams to support care for people experiencing
6 homelessness and providing valuable educational opportunities for medical students. Those
7 who testified discussed the importance of physicians leading street medicine teams, but
8 effective programs also utilize the broader health professional team under physician
9 supervision. An amendment was proposed to better align the language in the resolution to
10 other AMA policy regarding team-based care. Subclause 13 was struck by your Reference
11 Committee because it was viewed as unrelated to street medicine programs. Therefore, your
12 Reference Committee recommends that Resolution 931 be adopted as amended.

13
14 (20) RESOLUTION 933 – REDUCING DISPARITIES IN HIV
15 INCIDENCE THROUGH PRE-EXPOSURE
16 PROPHYLAXIS (PREP) FOR HIV

17
18 **RECOMMENDATION A:**

19
20 **That Resolution 933 be amended by addition and**
21 **deletion to read as follows:**

22
23 RESOLVED, That our American Medical Association
24 amend Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP)
25 for HIV” by addition to read as follows:

26
27 Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

28 1. Our AMA will educate physicians, physicians-in-training,
29 and the public about the effective use of pre-exposure
30 prophylaxis for HIV and the US PrEP Clinical Practice
31 Guidelines.

32 2. Our AMA supports the coverage of all approved PrEP
33 regimens in all clinically appropriate circumstances.

34 3. Our AMA supports the removal of insurance barriers for
35 all approved PrEP regimens, such as prior authorization,
36 mandatory consultation with an infectious disease
37 specialist, and other barriers that are not clinically relevant.

38 4. Our AMA advocates that individuals not be denied any
39 insurance on the basis of PrEP use.

40 5. Our AMA encourages the discussion of and education
41 about PrEP during routine sexual health counseling,
42 regardless of a patient’s current reported sexual behaviors.
43 (Modify Current HOD Policy)

44
45 **RECOMMENDATION B:**

46
47 Resolution 933 be adopted as amended.

48
49 **HOD ACTION: Resolution 933 adopted as amended.**

RECOMMENDED FOR ADOPTION IN LIEU OF

- 1
2
3 (21) RESOLUTION 906 – REQUIREMENT FOR COVID-19
4 VACCINATION IN PUBLIC SCHOOLS ONCE FULLY
5 FDA-AUTHORIZED
6

RECOMMENDATION A:

7
8
9 Policy H-440.808, “Digital Vaccine Credential Systems and
10 Vaccine Mandates in COVID-19” be amended by addition to
11 read as follows:
12

13 COVID-19 and COVID-19 vaccines raise unique
14 challenges.

15 To meet these challenges, our AMA:

16 1. Encourages the development of clear, strong, universal,
17 and enforceable federal guidelines for the design and
18 deployment of digital vaccination credentialing services
19 (DVCS), and that before decisions are taken to implement
20 use of vaccine credentials:

- 21 a. vaccine is widely accessible;
22 b. equity-centered privacy protections are in place to
23 safeguard data collected from individuals;
24 c. provisions are in place to ensure that vaccine credentials
25 do not exacerbate inequities; and
26 d. credentials address the situation of individuals for whom
27 vaccine is medically contraindicated.
28

29 2. Recommends that decisions to mandate COVID-19
30 vaccination, including, but not limited to for school
31 attendance for children and college/university students, be
32 made only:

- 33 a. After a vaccine has received full approval from the U.S.
34 Food and Drug Administration through a Biological Licenses
35 Application;
36 b. In keeping with recommendations of the Advisory
37 Committee on Immunization Practices for use in the
38 population subject to the mandate as approved by the
39 Director of the Centers for Disease Control and Prevention;
40 c. When individuals subject to the mandate have been
41 given meaningful opportunity to voluntarily accept
42 vaccination; and
43 d. Implementation of the mandate minimizes the potential
44 to exacerbate inequities or adversely affect already
45 marginalized or minoritized populations.
46

47 3. Encourages the use of well-designed education and
48 outreach efforts to promote vaccination to protect both
49 public health and public trust.

1 **RECOMMENDATION B:**

2
3 Policy H-440.808, “Digital Vaccine Credential Systems and
4 Vaccine Mandates in COVID-19” be adopted as amended
5 in lieu of Resolution 906.

6
7 **HOD ACTION: Policy H-440.808, “Digital Vaccine**
8 **Credential Systems and Vaccine Mandates in**
9 **COVID-19” adopted as amended in lieu of**
10 **Resolution 906.**

11
12 RESOLVED, That our American Medical Association encourage states to make COVID-19
13 vaccination a requirement for school attendance for children and college/university students
14 once the FDA grants full approval for COVID-19 vaccination for all relevant age groups. (New
15 HOD Policy)

16
17 Testimony for this item was mixed. Some noted the improved clinical outcomes for those who
18 have received COVID-19 vaccinations, noting that vaccination not only protects health, but
19 also prevents disruptions to education and loss of important resources for children and their
20 families. It was noted that there are laws against COVID-19 vaccine requirements in some
21 jurisdictions. It was also noted in testimony that our AMA has existing policy that outlines
22 recommendations on when to mandate COVID-19 vaccines and those recommendations go
23 beyond FDA granting full approval. To help ensure consistency, your Reference Committee
24 recommends amending existing policy on COVID-19 vaccine mandates to specifically
25 reference requirements for school attendance.

26
27 (22) RESOLUTION 912 – REEVALUATING THE FOOD AND
28 DRUG ADMINISTRATION'S CITIZEN PETITION
29 PROCESS

30
31 **RECOMMENDATION:**

32
33 That Alternate Resolution 912 be adopted in lieu of
34 Resolution 912.

35
36 RESOLVED, That our AMA work with relevant stakeholders
37 to advocate for further public transparency of citizen
38 petitions to the Food and Drug Administration, including the
39 relationship between citizen petitions and decisions to delay
40 generic approval, conflicts of interest to be disclosed, and
41 the time and resources expended on petition reviews.
42 (Directive to Take Action)

43
44 **HOD ACTION: Alternate Resolution 912 adopted in**
45 **lieu of Resolution 912.**

46
47 RESOLVED, That our American Medical Association support the research of anti-competitive
48 practices on the Food and Drug Administration's (FDA) citizen petitions process (New HOD
49 Policy); and be it further
50

1 RESOLVED, That our AMA advocate for further public transparency by the FDA in the content
2 of each petition, the relationship between citizen petitions and decisions to delay generic
3 approval, and the time and resources expended on petition reviews. (Directive to Take Action)

4
5 Your Reference Committee heard limited testimony on Resolution 912. The authors offered
6 new language to better condense the resolution into a single resolve clause without
7 fundamentally altering the intent of their proposal. Therefore, your Reference Committee
8 recommends that Alternate Resolution 912 be adopted.

9
10 (23) RESOLUTION 930 – ADDRESSING LONGITUDINAL
11 HEALTH CARE NEEDS OF CHILDREN IN FOSTER
12 CARE

13
14 **RECOMMENDATION A:**

15
16 That Alternate Resolution 930 be adopted in lieu of
17 Resolution 930.

18
19 RESOLVED, That our AMA support the construction of
20 health information systems to enhance information
21 exchange between both tribal and non-tribal child welfare
22 agencies and health care professionals; and be it further

23
24 RESOLVED, That our AMA advocate for the designation of
25 medical teams, and/or committees to longitudinally follow
26 children in foster care, including to ensure the provision of
27 continuity of care for children who are at the age of transition
28 out of foster care; and be it further

29
30 RESOLVED, That our AMA advocate for oversight of local,
31 tribal, and state child welfare systems by physicians with
32 expertise in pediatrics and child psychiatry.

33
34 RESOLVED, That our AMA promote existing medical
35 homes which provide continuity of care to children in foster
36 care when feasible (Directive to Take Action).

37
38 RESOLVED, That our AMA support the appointment of a
39 licensed pediatrician or family medicine physician (with
40 substantial pediatric experience) in each state with
41 experience in child welfare to the position of medical director
42 of child welfare and a psychiatrist with substantial child and
43 adolescent psychiatric experience to the position of
44 psychiatric medical director of child welfare for each Title IV-
45 E agency (New HOD Policy).

46
47 **RECOMMENDATION B:**

48
49 Policy D-350.977, “Addressing the Longitudinal Healthcare
50 Needs of American Indian Children in Foster Care” be
51 reaffirmed.

1 **HOD ACTION: Alternate Resolution 930 adopted in**
2 **lieu of Resolution 930 and Policy D-350.977,**
3 **“Addressing the Longitudinal Healthcare Needs of**
4 **American Indian Children in Foster Care”**
5 **reaffirmed.**
6

7 RESOLVED, That our American Medical Association support the construction of
8 computerized health information systems to enhance information exchange between both
9 tribal and non-tribal child welfare agencies and healthcare professionals (New HOD Policy);
10 and be it further

11 RESOLVED, That our AMA promote existing pediatric medical homes which provide
12 continuity of care to children in foster care (Directive to Take Action); and be it further

13 RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or
14 committees to longitudinally follow children in foster care (Directive to Take Action); and be it
15 further

16 RESOLVED, That our AMA support the appointment of a pediatrician in each state with
17 experience in child welfare to the position of state medical director of foster care health case
18 management in accordance with AAP guidelines to ensure standards of care are met (New
19 HOD Policy); and be it further

20 RESOLVED, That the AMA support the longitudinal stability and care of American Indian and
21 Alaska Native children in foster care by promoting the Indian Child Welfare Act. (New HOD
22 Policy)
23

24 Your Reference Committee heard testimony in support of the intent of this resolution.
25 Testimony noted that this population has special health care needs that need to be
26 highlighted. Your Reference Committee heard testimony regarding the need to broaden the
27 fourth Resolve beyond pediatricians and remove reference to AAP guidelines. Further,
28 amendments were proffered to include children aging out of foster care, and your Reference
29 Committee agreed with including this amendment. Your Reference Committee agrees and
30 has proposed amendments accordingly. Therefore, your Reference Committee recommends
31 Alternate Resolution 930 be recommended in lieu of Resolution 930. Further, it was noted that
32 some resolve statements are duplicative of recently adopted AMA policy and therefore your
33 Reference Committee is recommending reaffirmation of applicable policy.
34

35 Policy recommended for reaffirmation:
36

37 D-350.977 Addressing the Longitudinal Healthcare Needs of American Indian Children
38 in Foster Care

39 Our AMA: (1) recognizes the Indian Child Welfare Act of 1978 as a model in
40 American Indian and Alaska Native child welfare legislation; (2) supports federal
41 legislation preventing the removal of American Indian and Alaska Native children from
42 their homes by public and private agencies without cause; (3) will work with local and
43 state medical societies and other relevant stakeholders to support legislation
44 preventing the removal of American Indian and Alaska Native children from their
45 homes by public and private agencies without cause; and (4) supports state and
46 federal funding opportunities for American Indian and Alaska Native
47 child welfare systems.
48
49
50
51

RECOMMENDED FOR REFERRAL

- 1
2
3 (24) RESOLUTION 901 – OPPOSING THE USE OF
4 VULNERABLE INCARCERATED PEOPLE IN RESPONSE
5 TO PUBLIC HEALTH EMERGENCIES
6

RECOMMENDATION:

7
8
9 Resolution 901 be referred.

HOD ACTION: Resolution 901 referred.

10
11
12
13 RESOLVED, That our American Medical Association oppose the use of forced or coercive
14 labor practices for incarcerated populations (New HOD Policy); and be it further

15
16 RESOLVED, That our AMA support that any labor performed by incarcerated individuals or
17 other captive populations should include adequate workplace safety and fairness standards
18 similar to those outside of carceral institutions and support their reintegration into the
19 workforce after incarceration. (New HOD Policy)

20
21 Your Reference Committee heard mixed testimony for Resolution 901. It was noted that
22 although the intent was to avoid forced labor of incarcerated individuals, there were potential
23 downstream implications that could have unintended consequences. Further, it was noted that
24 there were potential constitutional law conflicts. Therefore, your Reference Committee
25 recommends that Resolution 901 be referred. Your Reference Committee also notes that
26 there are ethical issues around autonomy and human rights that requires further study.

- 27
28 (25) RESOLUTION 913 – SUPPORTING AND FUNDING
29 SOBERING CENTERS
30

RECOMMENDATION:

31
32
33 Resolution 913 be referred.

HOD ACTION: Resolution 913 referred.

34
35
36
37 RESOLVED, That our American Medical Association recognize the utility, cost effectiveness,
38 and racial justice impact of sobering centers (New HOD Policy); and be it further

39
40 RESOLVED, That our AMA support the maintenance and expansion of sobering centers (New
41 HOD Policy); and be it further

42
43 RESOLVED, That our AMA support ongoing research of the sobering center public health
44 model (New HOD Policy); and be it further

45
46 RESOLVED, That our AMA support the use of state and national funding for the development
47 and maintenance of sobering centers. (New HOD Policy)

48
49 Your Reference Committee heard mixed testimony regarding Resolution 913. There was
50 unanimous support that jails are not the ideal facilities for people who present intoxicated, due

1 to justice-involvement and lack of medical support. Additional testimony supported the need
2 for facilities for patients who are intoxicated, but do not need the acuity level of an emergency
3 department and may take critically needed resources from other patients. While the idea of
4 sobering centers was supported, there was no consensus on the definition of a sobering
5 center, both in scope and practice, and it was further noted that there was limited evidence to
6 support their efficacy. Multiple speakers supported the critical need for study across potential
7 models of care to support patients with substance use and misuse, which is not limited to
8 sobering centers. Therefore, your Reference Committee agrees that this is an important issue
9 with a high level of complexity and recommends Resolution 913 be referred.

10
11 (26) RESOLUTION 935 – GOVERNMENT MANUFACTURING
12 OF GENERIC DRUGS TO ADDRESS MARKET
13 FAILURES

14
15 **RECOMMENDATION:**

16
17 Resolution 935 be referred.

18
19 **HOD ACTION: Resolution 935 referred.**

20
21 RESOLVED, That our American Medical Association support the formation of a non-profit
22 government manufacturer of pharmaceuticals to produce small-market generic drugs. (New
23 HOD Policy)

24
25 Your Reference Committee heard mixed testimony on this resolution. Those providing
26 supportive testimony cited existing AMA policy calling for the fair pricing of pharmaceuticals
27 and noted California has already started this practice for the manufacture of generic drugs
28 and insulin. The authors proposed an amendment to expand the scope of the resolution to
29 include drugs for which no generics exist despite the expiration of its underlying patent, or
30 necessary medications which are facing shortages. Testimony in opposition noted that our
31 AMA should not be involved in promoting government manufacturing of pharmaceuticals and
32 that this would be a major departure from current AMA policy. Others noted that the Council
33 on Science and Public Health publishes annual reports on drug shortages, and that would be
34 an appropriate venue to consider government manufacturing of pharmaceuticals. Therefore,
35 your Reference Committee recommends that Resolution 935 be referred for consideration in
36 the Council's next drug shortages report.

37
38 (27) RESOLUTION 937 – INDICATIONS FOR METABOLIC
39 AND BARIATRIC SURGERY

40
41 **RECOMMENDATION:**

42
43 Resolution 937 be referred.

44
45 **HOD ACTION: Resolution 937 referred.**

46
47 RESOLVED, That our American Medical Association acknowledge and accept the new
48 American Society for Metabolic and Bariatric Surgery and International Federation for the
49 Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery
50 (New HOD Policy); and be it further
51

1 RESOLVED That our AMA immediately call for full acceptance of these guidelines by
2 insurance providers, hospital systems, policy makers, and government healthcare delivery
3 entities (Directive to Take Action); and be it further

4
5 RESOLVED, That our AMA work with all interested parties to lobby the legislative and
6 executive branches of government to affect public health insurance coverage to ensure
7 alignment with these new guidelines. (Directive to Take Action)

8
9 Your Reference Committee heard testimony noting that our AMA was not involved in and has
10 not reviewed the guidelines mentioned in this resolution and generally does not endorse or
11 accept guidelines that they were not involved in developing. Amendments were offered which
12 would instead include the core findings of the guidelines and remove reference to the
13 publishing organization. Your Reference Committee, however, notes that no one had the
14 chance to review and consider this amendment. The Council on Science and Public Health is
15 currently studying the appropriateness of body mass index as a clinical measure, which is
16 central to these guidelines. Therefore, your Reference Committee recommends that
17 Resolution 937 be referred for consideration in that report.

18
19 (28) RESOLUTION 938 – AMA STUDY THE EFFICACY OF
20 REQUIREMENTS FOR METAL DETECTION/WEAPONS
21 INTERDICTION SYSTEMS IN HEALTH CARE
22 FACILITIES

23
24 **RECOMMENDATION:**

25
26 Resolution 938 be referred.

27
28 **HOD ACTION: Resolution 938 referred.**

29
30 RESOLVED, That our American Medical Association Council on Science and Public Health
31 study the issues of 1) workplace violence as it impacts health care workers, patients, and
32 visitors, and 2) anticipated positive impacts of weapons detection and interdiction systems
33 toward reduction of workplace violence, so that our AMA can develop learned and data-based
34 recommendations and accompanying advocacy regarding proposed new requirements for the
35 deployment of these systems in health care settings, and share these recommendations with
36 accrediting bodies such as The Joint Commission, Liaison Committee on Medical Education,
37 Accreditation Council for Graduate Medical Education, and other relevant stakeholders,
38 including the American Hospital Association (Directive to Take Action).

39
40 Your Reference Committee heard mixed testimony regarding Resolution 938. All speakers
41 testified as to the critical importance of preserving the safety of physicians and other hospital
42 staff during a time in which there is a dramatic uptick in threats and violence against health
43 care personnel. However, the Council of Science and Public Health noted that this issue has
44 been studied on two separate occasions, and their conclusions supported a local, tailored
45 approach that considers local laws, jurisdictions, and risk factors rather than a blanket
46 approach for every hospital and care setting. Your Reference Committee agrees that this is a
47 critical issue, but one that should be a furtherance of previous studies, rather than starting
48 anew. As such, your Reference Committee recommends that Resolution 938 be referred.

49

RECOMMENDED FOR REFERRAL FOR DECISION

- 1
2
3 (29) RESOLUTION 911 – CRITICAL NEED FOR NATIONAL
4 EMERGENCY CARDIAC CARE (ECC) SYSTEM TO
5 ENSURE INDIVIDUALIZED, STATE-WIDE, CARE FOR
6 ST SEGMENT ELEVATION MYOCARDIAL INFARCTION
7 (STEMI), CARDIOGENIC SHOCK (CS) AND OUT-OF-
8 HOSPITAL CARDIAC ARREST (OHCA), AND TO
9 REDUCE DISPARITIES IN HEALTH CARE FOR
10 PATIENTS WITH CARDIAC EMERGENCIES

RECOMMENDATION:

11
12
13
14 That Resolution 911 be referred for decision.

15
16 RESOLVED, That our American Medical Association
17 encourage each the standardization of pre-hospital and
18 inpatient care for cardiac emergencies, to improve care
19 and enhance survival for all patients, especially for
20 those who receive socioeconomically, geographically,
21 and demographically disparate care, when they present
22 with ST Elevation Myocardial Infraction (STEMI), STEMI
23 with cardiogenic shock (STEMI-CS), and Out of
24 Hospital Cardiac Arrest (OHCA) (New HOD Policy); and
25 be it therefore.

26
27 RESOLVED, That our AMA encourages regional or
28 national hospital designation or categorization systems
29 for Emergency Cardiac Care Centers based on their
30 individual capabilities to provide ECC, analogous to
31 hospital designations or categorizations and systems of
32 care for Stroke and Trauma. (New HOD Policy)

33
34 **HOD ACTION: Alternate Resolution 911 be adopted**
35 **in lieu of Resolution 911.**

36
37 RESOLVED, That our American Medical Association encourage each state to standardize
38 pre-hospital and inpatient care for cardiac emergencies, with individualized systems of
39 Emergency Cardiac Care (ECC), specific for each state, to improve care and enhance survival
40 for all patients, especially for those citizens who receive sociodemographically disparate care,
41 when they present with cardiac emergencies (STEMI, STEMI-CS and OHCA) (New HOD
42 Policy); and be it therefore,

43
44 RESOLVED, That our AMA encourage states to designate hospitals as ECC Centers based
45 on their individual capabilities to provide ECC, much like the designations and systems of care
46 for Stroke and Trauma Centers. (New HOD Policy)

47
48 Your Reference Committee heard mixed testimony on this resolution, citing the success of
49 similar models of care seen for trauma or stroke centers. One speaker noted that in some
50 states, physicians have already begun to implement their own emergency cardiac care center

1 models, and that a nationwide approach may dramatically improve outcomes for these
2 patients. However, your Reference Committee heard concerns from multiple speakers that
3 the proposed model may negatively impact emergency care in rural settings, given that
4 funding and investment may be driven towards urban areas that might more easily satisfy
5 Emergency Cardiac Care (ECC) criteria. Given that ECC models would likely be dictated by
6 a myriad of state regulations, some testified to their worry that it could take significant time
7 and effort to untangle any inadvertent inequity in an ECC model. As such, your Reference
8 Committee recommends that this resolution be referred for decision to assess impact on rural
9 settings.

10
11 (30) RESOLUTION 917 – CARE FOR CHILDREN WITH
12 OBESITY

13
14 **RECOMMENDATION:**

15
16 Resolution 917 be referred for decision.

17
18 **HOD ACTION: Resolution 917 referred for decision.**

19
20 RESOLVED, That our American Medical Association actively support the education of
21 physicians on the morbidity of childhood obesity, the existence of effective treatment for this
22 condition, and the importance of patients obtaining bariatric care as early as possible
23 (Directive to Take Action); and be it further

24
25 RESOLVED, That our AMA support the development of multidisciplinary care programs for
26 children with obesity, inclusive of bariatric surgery care, access to medications, nutrition, and
27 mental health support (Directive to Take Action); and be it further

28
29 RESOLVED, That our AMA actively work to remove barriers to bariatric surgery, access to
30 medications, nutrition, and mental health support for the treatment of obesity in children.
31 (Directive to Take Action)

32
33 Your Reference Committee heard mixed testimony on Resolution 917. Testimony in support
34 noted that this resolution is additive to current AMA policy and that bariatric surgery has led
35 to decreases in mortality. However, there were questions around the evidence for promoting
36 bariatric surgery care for children as early as possible. An amendment was proffered to add
37 the term “medically appropriate” to describe the surgical procedures to avoid the undue
38 pressure of surgery, and a second proffered amendment sought to add education regarding
39 the impact of hormones on weight loss post-surgery. Furthermore, it was noted that existing
40 policy D-440.954, directs our AMA to conduct a landscape assessment of national
41 level obesity prevention and treatment initiatives, and calls on our AMA to convene an expert
42 advisory panel to counsel our AMA on how best to leverage its voice to address various issue
43 surrounding obesity, including evidence-based treatments. Therefore, your Reference
44 Committee recommends that Resolution 917 be referred for decision for inclusion in this
45 ongoing work and expert review.

1 (31) RESOLUTION 923 – PHYSICIAN EDUCATION AND
2 INTERVENTION TO IMPROVE PATIENT FIREARM
3 SAFETY
4

5 **RECOMMENDATION A:**
6

7 The third Resolve of Resolution 923 be referred for decision.
8

9 **RECOMMENDATION B:**
10

11 The fourth Resolve of Resolution 923 be amended by
12 addition and deletion to read as follows:
13

14 RESOLVED, That our AMA and all interested medical
15 societies educate the public about: (1) best practices for
16 firearm storage safety; (2) misconceptions families have
17 regarding child response to encountering a ~~gun~~ firearm
18 in the home; and (3) the need to ask other families with whom
19 the child interacts regarding the presence and storage of
20 ~~guns~~ firearms in other homes the child may enter. (Directive
21 to Take Action)
22

23 **RECOMMENDATION C:**
24

25 Resolution 923 be adopted as amended.
26

27 **HOD ACTION: Resolution 923 adopted as amended**
28 **and the third Resolve of Resolution 923 be referred.**
29

30 RESOLVED, That our American Medical Association and all interested medical societies
31 educate physicians about firearm epidemiology, anticipatory guidance, and lethal means
32 screening for and exploring potential restrictions to access to high-lethality means of suicide
33 such as firearms. Health care clinicians, including trainees, should be provided training on the
34 importance of anticipatory guidance and lethal means counseling to decrease firearm injuries
35 and deaths and be provided training introducing evidence-based techniques, skills and
36 strategies for having these discussions with patients and families (Directive to Take Action);
37 and be it further
38

39 RESOLVED, That our AMA and all interested medical societies educate physicians about
40 lethal means counseling in health care settings and intervention options to remove lethal
41 means, either permanently or temporarily from the home (Directive to Take Action); and be it
42 further
43

44 RESOLVED, That our AMA and all interested medical societies advocate for policies that
45 support the provision of funding for physicians to provide affordable rapid-access safe storage
46 devices to patients with firearms in the home (Directive to Take Action); and be it further
47

48 RESOLVED, That our AMA and all interested medical societies educate the public about: (1)
49 best practices for firearm storage safety; (2) misconceptions families have regarding child
50 response to encountering a gun in the home; and (3) the need to ask other families with whom

1 the child interacts regarding the presence and storage of guns in other homes the child may
2 enter. (Directive to Take Action)

3
4 Your Reference Committee heard mixed testimony on Resolution 923. The first two Resolve
5 statements are consistent with AMA policy and education on firearm safety, including lethal
6 means counseling. There were concerns raised about the approach outlined to achieve the
7 author's intended goals in the third Resolve. Some speakers sought referral due to the
8 complexity, cost, and concerns that while well intentioned, the implementation may lead to
9 increased physician liability. Additionally, editorial changes were made to ensure consistency
10 with existing AMA policy by using the term "firearm" rather than "gun." Therefore, your
11 Reference Committee recommends that the first and second Resolve statements be adopted,
12 the third Resolve be referred for decision, and the fourth Resolve be adopted as amended.

13
14 (32) RESOLUTION 936 – PROMOTING THE USE OF MULTI-
15 USE DEVICES AND SUSTAINABLE PRACTICES IN THE
16 OPERATING ROOM

17
18 **RECOMMENDATION A:**

19
20 Resolution 936 be referred for decision.

21
22 **RECOMMENDATION B:**

23
24 Policy H-480.959, "Reprocessing of Single-Use Medical
25 Devices" be reaffirmed.

26
27 **HOD ACTION: Resolution 936 referred and Policy H-
28 480.959, "Reprocessing of Single-Use Medical
29 Devices" reaffirmed.**

30
31 RESOLVED, That our American Medical Association advocate for research into and
32 development of intended multi-use operating room equipment and attire over devices,
33 equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.
34 (Directive to Take Action)

35
36 Your Reference Committee heard mixed testimony on Resolution 936. Testimony in support
37 noted that evaluation is needed to understand the evidence supporting equipment that can be
38 reused in the operating room versus equipment that is intended for single use. Amendments
39 were proffered to include sustainable practices in the office and perioperative environment.
40 Further, testimony noted that although there are some areas that are well-researched on the
41 sustainable practices in the operating room, a targeted approach is needed and therefore
42 recommended referral. It was also noted that existing AMA policy addresses reprocessing of
43 single-use medical devices and as a result your Reference Committee is recommending
44 reaffirmation of that policy. Therefore, your Reference Committee recommends that
45 Resolution 936 be referred for decision to update existing policy where applicable.

46
47 Policy recommended for reaffirmation:

48
49 H-480.959 Reprocessing of Single-Use Medical Devices

50 1. Our AMA: (a) supports the Food and Drug Administration (FDA) guidance titled
51 "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and

1 Hospitals" that was issued on August 2, 2000; (b) supports the development of device-
2 specific standards for the reuse and reprocessing of single-use medical devices
3 involving all appropriate medical and professional organizations and the medical
4 device industry; (c) encourages increased research by the appropriate organizations
5 and federal agencies into the safety and efficacy of reprocessed single-use medical
6 devices; and (d) supports the proper reporting of all medical device failures to the FDA
7 so that surveillance of adverse events can be improved.
8 2. Our AMA strongly opposes any rules or regulations regarding the repair or
9 refurbishment of medical tools, equipment, and instruments that are not based on
10 objective scientific data.