

**MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY**

F. Douglas Scutchfield, MD, MPH, FACPM

Introduced by the American College of Preventive Medicine

Whereas, F. Douglas “Scutch” Scutchfield, MD, a public health and preventive medicine leader for the world, the nation, and his native Kentucky, died on May 23, 2022; and

Whereas, Dr. Scutchfield, a native of Wheelwright, Kentucky, obtained his medical degree from the University of Kentucky College of Medicine, including an internship at Chicago Wesley Memorial Hospital (currently Northwestern Medical Center) and residency at the University of Kentucky Medical Center; and took additional graduate coursework in health services administration, business administration, economics, epidemiology and biostatistics; and was inducted into several honorary societies, including Omicron Delta Delta, Alpha Omega Alpha, Phi Beta Delta, and Delta Omega, and served as founding president of the Phi Kappa Phi chapter at the University of Kentucky; and

Whereas, Dr. Scutchfield was also awarded two honorary degrees: a Doctor of Science from the Eastern Kentucky University in Richmond in 2004 and a Doctor of Humane Letters from Pikeville College in 2007; and

Whereas, Dr. Scutchfield served in the U.S. Public Health Service as an Epidemic Intelligence Service Officer at the Centers for Disease Control and Prevention in Atlanta, and the U.S. Department of Health and Human Services’ Council on Health Promotion and Disease Prevention; and

Whereas, Dr. Scutchfield held numerous academic and administrative positions in which he taught and mentored students and faculty alike; he was a founder of the College of Community Health Services at the University of Alabama, and the founding director of two schools of public health: the Graduate School of Public Health at San Diego State University and the College of Public Health at the University of Kentucky; and

Whereas, Dr. Scutchfield served as a consultant to numerous health organizations including the National Center for Health Services Research; the National Heart, Lung, and Blood Institute; Project Hope; the Pan American Health Organization; the California Department of Health Services; California Health Care Foundation; United Way; the Good Samaritan Foundation; and Haifa University School of Public Health; and

Whereas, Dr. Scutchfield had an insatiable appetite for the spoken and written word and contributed to the fields of public health and preventive medicine by publishing more than 200 scientific abstracts, papers, and books; in addition, he held several key editorial positions: as Editor of the American Journal of Preventive Medicine for 15 years, and Editor-in-Chief of the Journal of Appalachian Health, one of his last and proudest editorial accomplishments as it provides the people and communities of Appalachia a resource to secure and ensure their health; in addition, he served on the editorial boards of the American Journal of Public Health; served in an editorial capacity for the Journal of Public Health Management and Practice, Annual Review of Public Health, California Physician, Western Journal of Medicine, Journal of Community Health, San Diego Physician, and Appalachia Medicine; classic textbooks such as Scutchfield and Keck’s Principles of Public Health Practice and many other books, book chapters, and peer-reviewed medical and public health articles; and received the 2022 Henry Clay Public Policy Book Award; and

Whereas, Dr. Scutchfield was a Fellow of the American Academy of Family Physicians, American College of Preventive Medicine, and the Royal Society of Health, and a member of the Fayette County Medical Society, Kentucky Medical Association, American Medical Association, Association of Teachers of Preventive Medicine (now known as APTR), and American Public Health Association; and

Whereas, Dr. Scutchfield served organized medicine in many leadership and consulting roles, notably for his commitment to service for the American Medical Association, where he served as chair of the Section Council on Preventive Medicine and on the Council on Medical Education, among other roles; and the American College of Preventive Medicine. Always willing to assist in some capacity, he gave his time full-heartedly and served in many capacities from representative or delegate to President or Chairman for the American Public Health Association, Association for Prevention Teaching and Research, Public Health Accreditation Board, Association of Schools of

Public Health, Residency Review Committee for Preventive Medicine, California Medical Association, Kentucky Medical Association, and multiple accrediting councils and boards; and

Whereas, Dr. Scutchfield had an international reputation and was a consultant to government and nongovernmental organizations in Panama, China, Saudi Arabia, Israel, and Germany; and

Whereas, Dr. Scutchfield received numerous honors, medals, and awards in his lifetime, including the prestigious Sedgwick Medal of the American Public Health Association, the William Beaumont Award and Distinguished Services Award from the American Medical Association, the Honorable Order of Kentucky Colonels, Key to the City of Selma, Alabama, the Commonwealth Award, Duncan Clark Award, University of Kentucky Public Health Hall of Fame, and the University of Kentucky Libraries Medallion for Intellectual Achievement; and

Whereas, Dr. Scutchfield's generous nature was tempered by a deep need for reciprocation, in part what drew him to the work of Thomas Merton, who articulated the need for human contact to bridge the spiritual gulf. Dr. Scutchfield believed strongly in the importance of humanity to those in the healthcare profession and explored his spirituality at the Abbey of Gethsemani, studying Merton's work; and

Whereas, Dr. Scutchfield was the ultimate networker. He seemed to know everyone, and everyone knew him. His legacy will live on through the countless people he took under his wing and mentored. He was a role model to everyone. His easy demeanor made him approachable to all and he made everyone feel as if they were important; and

Whereas, Dr. Scutchfield was an advice contributor and towering figure to the field of public health and preventive medicine and his energy for change, an untiring determination to innovate, move the needle, make phone calls, and get people on board helped shape the course of the advancement and betterment of the field at large and the overall health of the nation; and

Whereas, Dr. Scutchfield will be remembered not only for his stewardship, leadership, and scholarship in medicine but also his giving spirit, warm heart, larger-than-life personality, sacrifice, service, stories, laconic humor, and iconic smile. He never missed an opportunity to praise a colleague, fantasize about the future of public health, or tell an entertaining story about his love of his home state of Kentucky. He never lost touch with his humble beginnings while being able to navigate smoothly between the erudite elites in academic and policy circles and the local folks he served from beginning to end; and

Whereas, Dr. Scutchfield is survived by his beloved wife of greater than 50 years, Phyllis Scutchfield, JD, LLM, of Lexington, Kentucky; his son Alex L. Scutchfield, JD, and daughter-in-law Jennifer of Lexington, Kentucky, and his two grandchildren, Cassandra Ann and Ethan Layne; and his brother Scott Scutchfield and Scott's wife Margaret; and touched the lives of so many family members, friends, colleagues, mentees, and patients, leaving this world a better place and living on in the hearts of so many; therefore be it

RESOLVED, That our American Medical Association note with great sadness the passing of F. Douglas "Scutch" Scutchfield, MD, MPH, FACPM, with recognition and thanks for his many contributions to our Association and this great nation; and be it further

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

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, November 13. The following resolutions were dealt with on the reaffirmation calendar: 7, 207, 217, 218, 220, 314, 315, 803, 807, 922, and 927.

The following resolutions were not considered based on recommendations from the Resolution Committee: 1, 4, 10, 14, 204, 212, 221, 225, 226, 301, 603, 604, 605, 608, 825, 903, 914, 925, 932, 934, and 939.

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

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

RESOLUTION 1 WAS NOT CONSIDERED

2. ASSESSING THE HUMANITARIAN IMPACT OF SANCTIONS

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

**HOD ACTION: ALTERNATE RESOLUTION 2 ADOPTED
IN LIEU OF RESOLUTIONS 2 AND 6 See
Policy H-65.945, D-65.993, and H-65.994**

RESOLVED, That our American Medical Association recognize that economic sanctions can negatively impact health and exacerbate humanitarian crises; and be it further

RESOLVED, that Policy H-65.993 be amended by addition and deletion as follows:

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

RESOLVED, that Policy H-65.994 be amended by addition and deletion as follows:

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

3. INDIGENOUS DATA SOVEREIGNTY **Introduced by Medical Student Section**

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-460.884

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

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

RESOLVED, That our AMA encourage the use and regular review of data-sharing agreements for all studies between academic medical centers and AI/AN Tribes and Villages be mutually agreed upon and aligned with AI/AN Tribes' and Villages' preferences; and be it further

RESOLVED, That our AMA encourage the National Institutes of Health and other stakeholders to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the creation and maintenance of IRBs.

RESOLUTION 4 WAS NOT CONSIDERED

5. STRENGTHENING INTERVIEW GUIDELINES FOR AMERICAN INDIAN AND ALASKA NATIVE MEDICAL SCHOOL, RESIDENCY, AND FELLOWSHIP APPLICANTS **Introduced by Medical Student Section**

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

HOD ACTION: ADOPTED
See Policy H-295.852

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

6. ASSESSING THE HUMANITARIAN IMPACT OF SANCTIONS **Introduced by Medical Student Section**

Resolution 6 was considered with Resolution 2.
See Resolution 2.

RESOLVED, That our American Medical Association recognize that economic sanctions can negatively impact health and exacerbate humanitarian crises; and be it further

RESOLVED, That our AMA support legislative and regulatory efforts to study the humanitarian impact of economic sanctions imposed by the United States.

7. CONSENT FOR SEXUAL AND REPRODUCTIVE HEALTHCARE

**Introduced by International Medical Graduates Section, American Psychiatric Association,
American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry**

Considered on reaffirmation calendar

**HOD ACTION: POLICIES E-2.2.2 AND E-2.2.3 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with state and county medical societies to advocate for legislation and legal protections: 1) allowing minors (age 12 or above) to consent for sexual and reproductive health care; 2) allowing minors to consent for prenatal care and delivery services; and 3) protecting physician autonomy to provide sexual and reproductive health care with minor consent, without parental consent.

**8. SUPPORT FOR PHYSICIANS PRACTICING EVIDENCE-BASED MEDICINE
IN A POST-DOBBS ERA**

Introduced by Colorado, Arizona

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-5.998

RESOLVED, That our American Medical Association Task Force developed under HOD Policy G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted,” publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws; and be it further

RESOLVED, That our AMA work to facilitate support, including legal support through the AMA Litigation Center, as may be appropriate, to physicians that are targeted for practicing in accordance with accepted standards of medical care and medical ethics in the face of legal constraint or any other disciplinary action; and be it further

RESOLVED, That our AMA advocate for affirmative protections for “conscientious provision” of care in accordance with accepted standards of medical care and medical ethics in hostile environments on par with protection of “conscientious objection.”

9. MEDICAL DECISION-MAKING AUTONOMY OF THE ATTENDING PHYSICIAN

Introduced by Mississippi

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

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association advocate that no matter what may change in regard to a physician’s employment or job status, that there is a sacred relationship between an attending physician and his/her patient that leads the patient’s attending physician to hold the ultimate authority in the medical decision-making that affects that patient; and be it further

RESOLVED, That our AMA advocate strongly that if there is a unique circumstance that puts the attending physician’s care into question by a hospital administrator of any sort such as listed above but certainly not limited to that list—physician or not—in the event of a disagreement between an administrator and the attending physician regarding a decision one would call a mere judgment call, the onus would be on the administrator to prove to an ethics committee why the attending physician is wrong prior to anyone having the authority to overturn or overrule the order of the physician attending the patient directly; and be it further

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

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

RESOLUTION 10 WAS NOT CONSIDERED

11. ADVOCATING FOR THE INFORMED CONSENT FOR ACCESS TO TRANSGENDER HEALTH CARE Introduced by Washington

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

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association advocate and encourage the adoption of an informed consent model when determining coverage for transgender health care services.

12. GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS Introduced by Medical Student Section

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

HOD ACTION: ADOPTED AS FOLLOWS See Policy D-140.950

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 for adult and pediatric populations 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 chaperones and attempting to accommodate that preference as able; and (e) Use of chaperone at physician request when physician deems necessary.

RESOLUTION 13 WAS WITHDRAWN

RESOLUTION 14 WAS NOT CONSIDERED

15. RESTRICTING DEROGATORY AND STIGMATIZING LANGUAGE OF ICD-10 CODES

Introduced by Washington

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

HOD ACTION: **ADOPTED AS FOLLOWS**
 See Policy D-70.942

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 adopt destigmatizing terminology in ICD-10 and future ICD codes and to eliminate existing stigmatizing diagnostic synonyms.

16. INCREASING FEMALE REPRESENTATION IN ONCOLOGY CLINICAL TRIALS

Introduced by Academic Physicians Section

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

HOD ACTION: **ADOPTED AS FOLLOWS**
 See Policy H-460.911

RESOLVED, That our American Medical Association amend Policy H-460.911, “Increasing Minority Participation in Clinical Research,” by addition and deletion as follows:

H-460.911, Increasing Minority, Female and Other Unrepresented Group Participation in Clinical Research

1. Our AMA advocates that:

- a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
- b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
- c. Resources be provided to community level agencies that work with those minorities, females, and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Black individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities, females, and other underrepresented groups in clinical trials:

- a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders’ support, and listening to community’s needs;
- b. Increased outreach to ~~female~~ all physicians to encourage recruitment of ~~female~~ patients from underrepresented groups in clinical trials;
- c. Continued ~~minority physician~~ education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients;
- d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
- e. Fiscal support for minority, female, and other underrepresented groups recruitment efforts and increasing trial accessibility ~~through transportation, child care, reimbursements, and location.~~

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race, and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

17. SUPERVISION OF NON-PHYSICIAN PRACTITIONERS BY PHYSICIANS

Introduced by Organized Medical Staff Section

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

HOD ACTION: ADOPTED AS FOLLOWS

TITLE CHANGED

See Policy D-35.978

RESOLVED, That our American Medical Association advocate to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; and be it further

RESOLVED, That our AMA advocate that physician supervision should be explicitly defined and mutually agreed upon; and be it further

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

RESOLVED, That our AMA advocate that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and be it further

RESOLVED, That our AMA advocate that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation.

REFERENCE COMMITTEE B

201. PHYSICIAN REIMBURSEMENT FOR INTERPRETER SERVICES

Introduced by American Association of Clinical Urologists, American Urological Association

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS

See Policy D-385.946

RESOLVED, That our American Medical Association prioritize physician reimbursement for interpreter services, including American Sign Language, and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services; and be it further

RESOLVED, That our AMA continue to work with interested state and specialty societies to advocate for physician reimbursement for interpreter services, including American Sign Language, for commercial health plans, workers' compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services.

202. ADVOCATING FOR STATE GME FUNDING
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-305.967

RESOLVED, That our American Medical Association publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

203. INTERNATIONAL MEDICAL GRADUATE EMPLOYMENT
Introduced by Missouri

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-255.965

RESOLVED, That our American Medical Association support federal legislation that reduces the administrative burden and streamlines the process of hiring international medical graduates.

RESOLUTION 204 WAS NOT CONSIDERED

205. WAIVER OF DUE PROCESS CLAUSES
Introduced by Missouri

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-230.950

RESOLVED, That our American Medical Association support legislation that bans the use of “Waiver of Due Process” provisions within physician employment contracts and declares such current provisions to be void.

206. NURSING SHORTAGE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-360.991, H-35.996 and H-160.947

RESOLVED, That our American Medical Association review existing literature on the nursing workforce shortage, including the impact of increased enrollment in nurse practitioner programs; and be it further

RESOLVED, That our AMA reaffirm existing Policies H-160.947, “Physician Assistants and Nurse Practitioners,” and H-35.996, “Status and Utilization of New or Expanding Health Professionals in Hospitals.”

207. PRESERVING PHYSICIAN LEADERSHIP IN PATIENT CARE
Introduced by Resident and Fellow Section

Considered on reaffirmation calendar

**HOD ACTION: POLICIES H-275.925, H-405.951, AND H-405.969 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association create a national targeted ad campaign to educate the public about the training pathway of physicians compared to non-physician providers; and be it further

RESOLVED, That our AMA reaffirm our opposition to physicians being referred to as “providers” in healthcare settings; and be it further

RESOLVED, That our AMA conduct a review of the AMA policy compendium and replace conflicting policies referring to physicians as “providers” with the term “physician” when appropriate and report back at the 2023 Annual Meeting.

208. FACTORS CAUSING BURNOUT

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: ALTERNATE RESOLUTION 208 ADOPTED
IN LIEU OF RESOLUTION 208**
See Policy H-405.948

RESOLVED, That our AMA recognize that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

RESOLUTION 209 WAS WITHDRAWN

**210. ELIMINATION OF SEASONAL TIME CHANGES AND ESTABLISHMENT
OF PERMANENT STANDARD TIME**
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-440.802

RESOLVED, That our American Medical Association support the elimination of seasonal time changes; and be it further

RESOLVED, That our AMA support the adoption of year-round standard time.

211. SUBSTANCE HARM REDUCTION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-95.987

RESOLVED, That our American Medical Association amend current Policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:

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

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

6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

and be it further

RESOLVED, That our AMA rescind Policy 95.989.

RESOLUTION 212 WAS NOT CONSIDERED

213. HAZARD PAY DURING A DISASTER EMERGENCY
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-130.970 AND D-390.947 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the federation of medicine to advocate for state or federal programs that would provide hazard pay bonuses to physicians and other healthcare staff delivering care during a state or federal disaster emergency.

214. UNIVERSAL GOOD SAMARITAN STATUTE
Introduced by Georgia

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association help protect patients in need of emergency care and protect physicians and other responders by advocating for a national “universal” Good Samaritan Statute; and be it further

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

**215. ELIMINATING PRACTICE BARRIERS FOR INTERNATIONAL MEDICAL GRADUATE
PHYSICIANS DURING PUBLIC HEALTH EMERGENCIES**
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-255.973

RESOLVED, That our American Medical Association advocate to allow currently practicing physicians, including international medical graduates, with valid licenses in states and territories of the U.S. in health professional shortage areas to have temporary access to all unique and expedited licensing options, both inside and outside of the state of their practice during public health emergencies, to facilitate workforce utilization at the time of critical shortage.

**216. EXPANDING PARITY PROTECTIONS AND COVERAGE OF MENTAL HEALTH AND
SUBSTANCE USE DISORDER CARE**
**Introduced by American Society of Addiction Medicine, American Psychiatric Association,
American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry,
American Academy of Child and Adolescent Psychiatry**

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-185.916 and H-185.974

RESOLVED, That our American Medical Association amend Policy H-185.974, “Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs,” by addition and deletion to read as follows:

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

1. Our AMA supports parity of coverage for mental ~~illness, alcoholism, health, and~~ substance use, and eating disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C, and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders.

and be it further

RESOLVED, That our AMA support requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws.

217. RESTRICTIONS ON THE OWNERSHIP OF HOSPITALS BY PHYSICIANS
Introduced by Mississippi

Considered on reaffirmation calendar

HOD ACTION: POLICY H-215.960 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate to alleviate any restriction upon physicians from owning, constructing and/or expanding any hospital facility type - in the name of patient safety, fiscal responsibility, transparency and in acknowledgment of physicians everywhere who have given of themselves valiantly in the name of patient care.

218. SCREENING AND APPROVAL PROCESS FOR THE OVER-THE-COUNTER SALE OF
SUBSTANCES WITH POTENTIAL FOR RECREATIONAL USE AND ABUSE
Introduced by Mississippi

Considered on reaffirmation calendar

HOD ACTION: POLICY H-95.940 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the implementation of a national impact on substance abuse by working on model state legislation for state level screening and approval programs to fall under the authority of the State Health Officer which would bestow the authority on his/her office to approve or deny the over-the-counter availability and/or sales of any substance with the potential to be recreationally used and/or abused based on anecdotal, scientific or any other relevant and available evidence to help determine such approval or denial. An appeals process, should one be necessary, would be available by way of appeal to the Board of Health directly by the manufacturer or distributor of such substance that was denied by the State Health Officer initially; and be it further

RESOLVED, That our AMA work with stakeholders to create a public education campaign regarding these unregulated substances.

219. HOLD ACCOUNTABLE THE REGULATORY BODIES, HOSPITAL SYSTEMS, STAFFING
ORGANIZATIONS, MEDICAL STAFF GROUPS, AND INDIVIDUAL PHYSICIANS
SUPPORTING SYSTEMS OF CARE PROMOTING DIRECT SUPERVISION OF
EMERGENCY DEPARTMENTS BY NURSE PRACTITIONERS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED FOR DECISION
AS FOLLOWS

RESOLVED, That our American Medical Association advocate that board certified or board eligible physicians, preferably those with training and experience in emergency medicine and/or trauma care, are the only members of the health care team qualified to supervise the provision of emergency care services in the emergency department and such supervision should be direct.

**220. EXTEND TELEMEDICINE TO OUT OF STATE ENROLLED COLLEGE STUDENTS TO AVOID
EMERGENCY ROOM AND INPATIENT PSYCHIATRIC HOSPITALIZATIONS WHEN IN CRISIS**
Introduced by Mississippi

Considered on reaffirmation calendar

**HOD ACTION: POLICY D-480.960 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association work with state medical associations, the American Psychiatric Association, the American Osteopathic Association, and the Federation of State Medical Boards to advocate to Congress that legislation be introduced and passed to extend telemedicine coverage for out of state enrolled college and graduate-level students with an established physician-patient relationship to avoid emergency room and inpatient psychiatric hospitalizations.

RESOLUTION 221 WAS NOT CONSIDERED

222. ALLOCATE OPIOID FUNDS TO TRAIN MORE ADDICTION TREATMENT PHYSICIANS
Introduced by Washington

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-95.918

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

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

**223. OPPOSITION TO CRIMINALIZATION OF AND CIVIL LIABILITY FOR PREGNANCY
LOSS AS THE RESULT OF MEDICALLY NECESSARY CARE**

**Introduced by Association for Clinical Oncology, American Society for Radiation Oncology,
American Society of Hematology**

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED**
See Policy D-160.911

RESOLVED, That our American Medical Association advocate that pregnancy loss shall not be criminalized for physicians or patients; and be it further

RESOLVED, That our AMA advocate that physicians and patients should not be held civilly and/or criminally liable for pregnancy loss as a result of medically necessary care.

224. FERTILITY PRESERVATION

**Introduced by Association for Clinical Oncology, American Society for Radiation Oncology,
American Society of Hematology**

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: POLICY H-185.990 AMENDED IN LIEU OF RESOLUTION 224
POLICIES D-5.999 AND H-160.946 REAFFIRMED**

RESOLVED, That Policy H-185.990 be amended by addition and deletion to read as follows:

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

1. Our AMA ~~encourages~~ advocates for 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~~ advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will ~~lobby for appropriate~~ support state and federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, including but not limited to cryopreservation of embryos, sperm, oocytes, and ovarian and testicular tissue.
3. Our AMA ~~encourages~~ advocates for the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility, and supports access to fertility preservation services for those affected.

RESOLVED, That Policies D-5.999, “Preserving Access to Reproductive Health Services,” and H-160.946, “The Criminalization of Health Care Decision Making,” be reaffirmed.

RESOLUTION 225 WAS NOT CONSIDERED

RESOLUTION 226 WAS NOT CONSIDERED

227. ACCESS TO METHOTREXATE AND OTHER MEDICATIONS BASED ON CLINICAL DECISIONS
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-5.997

RESOLVED, That our American Medical Association oppose restrictions on prescribing, distributing, or dispensing of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination; and be it further

RESOLVED, That our AMA work with relevant stakeholders to provide educational guidance on laws, regulations, or other policies that impede the prescribing, distributing, or dispensing of methotrexate and other medications because of their impact or perceived impact on a pregnancy.

228. REQUIREMENTS FOR PHYSICIAN SELF-REPORTING OF OUTPATIENT MENTAL HEALTH SERVICES, TREATMENTS OR MEDICATIONS TO CREDENTIALING AGENCIES AND INSURERS
Introduced by Academic Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-275.945 and H-295.858

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

RESOLVED, That Policy H-295.858 be reaffirmed.

229. EXPANDING SUPPORT FOR ACCESS TO ABORTION CARE

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: ALTERNATE RESOLUTION 229 ADOPTED
IN LIEU OF RESOLUTIONS 229 AND 231**
See Policy D-5.996

RESOLVED, That our AMA advocate for broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; and be it further

RESOLVED, That our AMA advocate for explicit codification of legal protections to ensure broad, equitable access to abortion services; and be it further

RESOLVED, That our AMA advocate for equitable participation by physicians who provide abortion care in insurance plans and public programs; and be it further

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

230. INCREASED HEALTH PRIVACY ON MOBILE APPS IN LIGHT OF ROE V. WADE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-315.968

RESOLVED, That American Medical Association Policy D-315.968, "Supporting Improvement to Patient Data Privacy," be amended by addition to read as follows:

D-315.968, "Supporting Improvement to Patient Data Privacy"

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

231. EXPANDING SUPPORT FOR ACCESS TO ABORTION CARE**Introduced by Medical Student Section****Resolution 231 was considered with Resolution 229.
See Resolution 229.**

RESOLVED, That our American Medical Association recognize that policies and legislation that limit access to abortion care are serious threats to public health; and be it further

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

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

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

232. OBTAINING PROFESSIONAL RECOGNITION FOR MEDICAL SERVICE PROFESSIONALS**Introduced by Organized Medical Staff Section**

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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

233. URGENT AMA ASSISTANCE TO PUERTO RICO AND FLORIDA AND A LONG-RANGE PROJECT FOR PUERTO RICO (LATE 1001)**Introduced by Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia**

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-290.973, D-290.975, and H-390.953

RESOLVED, That our American Medical Association promptly urge all relevant government agencies and Congress to provide available federal disaster assistance to the Territory of Puerto Rico and the State of Florida; and be it further

RESOLVED, That AMA Policy H-390.953, “Medicare Payments for Physicians’ Services in Puerto Rico,” which calls on our AMA to support the elimination of inequities in Medicare reimbursement so that physicians’ fees for Medicare patients in Puerto Rico are adjusted according to the Medicare regulations applicable in the continental United States, be reaffirmed; and be it further

RESOLVED, That Policy D-290.975 be amended by addition and deletion to read as follows:

1. Our AMA will urge and advocate the U.S. Congress to quickly pass legislation to provide adequately, stable, long-term funding for Puerto Rico’s, ~~and~~ the U.S. Virgin Islands’, and other U.S. territories’ Medicaid Programs.

2. Our AMA will urge and advocate for the Centers for Medicare and Medicaid Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers to help restore access to health care services in Puerto Rico and the U.S. Virgin Islands.

REFERENCE COMMITTEE C

RESOLUTION 301 WAS NOT CONSIDERED

302. EXPANDING EMPLOYEE LEAVE TO INCLUDE MISCARRIAGE AND STILLBIRTH

Reference committee hearing: see report of Reference Committee C.

**HOD ACTION: ALTERNATE RESOLUTION 302 ADOPTED
IN LIEU OF RESOLUTIONS 302, 303, AND 308**
See Policies H-405.960 and H-420.979

RESOLVED, Tat Policy H-405.960, “Policies for Parental, Family, and Medical Necessity Leave,” be amended by addition and deletion, to read as follows:

H-405.960, “Policies for Parental, Family, and Medical Necessity Leave”

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

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

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

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

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

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

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

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

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

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

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

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

~~10.~~ 12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

~~11.~~ 13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

~~12.~~ 14. Our AMA encourages flexibility in residency ~~training~~ programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees ~~house staff~~.

~~13.~~ 15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

~~14.~~ 16. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship.

and be it further

RESOLVED, That Policy H-420.979, “AMA Statement on Family and Medical Leave,” be amended by addition, to read as follows:

H-420.979, “AMA Statement on Family and Medical Leave”

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

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee’s immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association’s normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

303. MEDICAL STUDENT LEAVE POLICY
Introduced by Medical Student Section

Resolution 303 was considered with Resolution 302.
See Resolution 302.

RESOLVED, That our American Medical Association amend Policy H-405.960 “Policies for Parental, Family and Medical Necessity Leave” by addition and deletion to read as follows:

H-405.960, “Policies for Parental, Family and Medical Necessity Leave”

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

1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement.
2. Recommended components of parental leave policies for ~~medical students and~~ physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians’ workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
- ~~8-~~ 9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
- ~~9-~~ 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
- ~~10-~~ 11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
- ~~11-~~ 12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
- ~~12-~~ 13. Our AMA encourages flexibility in residency training programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees ~~house staff~~.
- ~~13-~~ 14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
- ~~14-~~ 15. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship.

**304. PROTECTING STATE MEDICAL LICENSING BOARDS FROM
EXTERNAL POLITICAL INFLUENCE
Introduced by New York**

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED
See Policy D-270.984

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards and other interested parties to minimize external interference with the independent functioning of state medical disciplinary and licensing boards.

**305. ENCOURAGING MEDICAL SCHOOLS TO SPONSOR PATHWAY PROGRAMS TO
MEDICINE FOR UNDERREPRESENTED GROUPS
Introduced by Illinois**

Reference committee hearing: see report of Reference Committee C.

**HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED**
See Policy H-350.960

RESOLVED, That our American Medical Association urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; and be it further

RESOLVED, That our AMA encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; and be it further

RESOLVED, That our AMA recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; and be it further

RESOLVED, That our AMA encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and be it further

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

**306. INCREASED CREDIT FOR CONTINUING MEDICAL EDUCATION PREPARATION
Introduced by New York**

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-300.975

RESOLVED, That our American Medical Association, through its AMA-PRA credit system, allow physicians to claim an amount of Category 1 CME credits that accurately reflects the learning associated with preparing and presenting CME programs. Physicians may claim up to four (4) Category 1 CME hours per each hour of presentation.

307. FAIR COMPENSATION OF RESIDENTS AND FELLOWS
Introduced by Arkansas

Reference committee hearing: see report of Reference Committee C.

**HOD ACTION: POLICIES H-305.930 AND H-310.912 REAFFIRMED
 IN LIEU OF FOLLOWING RESOLUTION**

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; 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; and be it further

RESOLVED, That our AMA amend the Residents and Fellows Bill of Rights: H-310.912 (last modified 2022) accordingly.

308. PAID FAMILY/MEDICAL LEAVE IN MEDICINE

Introduced by American College of Radiology, American Academy of Pediatrics, Maryland, Radiological Society of North America, Society of Interventional Radiology, American Society for Radiation Oncology, American Institute of Ultrasound in Medicine, American Roentgen Ray Society, American College of Radiation Oncology, Association of University Radiologists, American College of Nuclear Medicine, American Society of Neuroradiology, Society of Nuclear Medicine and Molecular Imaging, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

**Resolution 308 was considered with Resolution 302.
 See Resolution 302.**

RESOLVED, That our American Medical Association Policy H-405.960 “Policies for Parental Family and Medical Necessity Leave” be amended by addition and deletion to read as follows:

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

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians’ workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental, family, and medical necessity leave policies a ~~six~~-twelve-week minimum leave allowance, with the understanding that no ~~parent~~ individual should be required to take a minimum leave.

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

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

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

~~78.~~ Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

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

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

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

~~1112.~~ Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

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

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

~~1415.~~ These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

309. BEREAVEMENT LEAVE FOR MEDICAL STUDENTS AND PHYSICIANS

Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS

See Policy H-405.947

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

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

2. Our AMA will study components of compassionate leave policies for medical students and physicians to include:

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

- b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
 - c. whether leave is paid or unpaid;
 - d. whether obligations and time must be made up; and
 - e. whether make-up time will be paid.
3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
4. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
5. Our AMA will study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.

310. ENFORCE AMA PRINCIPLES ON CONTINUING BOARD CERTIFICATION **Introduced by Michigan**

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-275.924 and D-275.954

RESOLVED, That Policy H-275.924 be reaffirmed; and be it further

RESOLVED, That our AMA continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

311. SUPPORT HYBRID INTERVIEW TECHNIQUES FOR ENTRY TO GRADUATE MEDICAL EDUCATION

Reference committee hearing: see report of Reference Committee C.

**HOD ACTION: ALTERNATE RESOLUTION 311 ADOPTED
IN LIEU OF RESOLUTION 311**
See Policy D-295.303

RESOLVED, That our AMA work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents; and be it further

RESOLVED, That our AMA encourage appropriate stakeholders, such as the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Intealth, and Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews

312. REPORTING OF RESIDENCY DEMOGRAPHIC DATA
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-405.960

RESOLVED, That our American Medical Association work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity; and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty; and be it further

RESOLVED, That Policy H-405.960 (14) be amended by addition to read as follows:

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

313. REQUEST A TWO-YEAR DELAY IN ACCME CHANGES TO STATE MEDICAL SOCIETY RECOGNITION PROGRAM

Introduced by Oklahoma, Arizona, District of Columbia, Hawaii, Iowa, Kansas, Kentucky, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Utah, Virginia, Alabama, Illinois

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-300.968

RESOLVED, That our American Medical Association collaborate with Accreditation Council for Continuing Medical Education (ACCME) to delay implementation of any changes to the state medical society accreditor program until such time that a mutual agreement can be reached. During that time, AMA, ACCME, and state medical societies will work collaboratively to study the impact and unintended consequences of the proposed action and create a plan that is in the best interests of all parties, including the continuing medical education providers currently accredited by state medical societies.

314. BALANCING SUPPLY AND DEMAND FOR PHYSICIANS BY 2030
Introduced by Michigan

Considered on reaffirmation calendar

**HOD ACTION: POLICIES H-200.954, H-200.955, H-200.972, H-465.988, AND
D-305.958 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association take action on all fronts to advocate for and implement remedies that will rebalance the supply and demand equation for primary care physicians by 2030; and be it further

RESOLVED, That our AMA reaffirm AMA Policies H-200.954, H-200.955, H-200.972, H 465.988, and D-305.958.

315. BEDSIDE NURSING AND HEALTH CARE STAFF SHORTAGES**Introduced by Michigan***Considered on reaffirmation calendar***HOD ACTION: POLICY D-360.998 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our AMA amend AMA Policy D-360.998, “The Growing Nursing Shortage in the United States,” by addition to read as follows:

Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;

(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;

(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;

(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;

(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care;

(6) will approach appropriate stakeholders such as the American Hospital Association to collaborate on the identification of and advocacy for short- and long-term strategies and solutions to address nursing and other health care staff shortages in order to promote a stable work force and career longevity.

316. RECOGNIZING SPECIALTY CERTIFICATIONS FOR PHYSICIANS**Introduced by Congress of Neurological Surgeons, American Association of Neurological Surgeons***Reference committee hearing: see report of Reference Committee C.***HOD ACTION: ADOPTED AS FOLLOWS
SECOND RESOLVE REFERRED
See Policy H-275.926**

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

Our AMA:

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

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

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

- (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
- (5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
- (6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

[Editor's note: The following resolve clause, with amendments proposed by the reference committee, was referred.]

RESOLVED, That our AMA advocate for federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other health care stakeholders ~~and the public~~ to define physician board certification as establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

317. SUPPORT FOR GME TRAINING IN REPRODUCTIVE SERVICES **Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
see Policy D-5.999, H-100.948, H-295.923, and H-425.969

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

Medical Training and Termination of Pregnancy

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA ~~supports~~ will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.
4. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.
- 3 5. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Relevant Residency Review Committees ~~Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.~~

and be it further

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

RESOLVED, That AMA Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended by addition and deletion to read as follows:

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

REFERENCE COMMITTEE F

601. AMA WITHDRAW ITS ORGANIZATIONAL STRATEGIC PLAN TO EMBED RACIAL JUSTICE AND ADVANCE HEALTH EQUITY **Introduced by Louisiana, South Carolina**

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and rewrite the recommendations for correcting its past support for racially discriminating behavior with removal of the inflammatory rhetoric.

602. FINDING CITIES FOR FUTURE AMA CONVENTIONS/MEETINGS **Introduced by Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia, Texas, American College of Radiology**

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association amend Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” by addition and deletion to read as follows:

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has regulation or enacted comprehensive legislation requiring smoke-free worksites and

public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.

4. It is the policy of our AMA not to ~~hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or~~ pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.

7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities.

RESOLUTION 603 WAS NOT CONSIDERED

RESOLUTION 604 WAS NOT CONSIDERED

RESOLUTION 605 WAS NOT CONSIDERED

606. PATIENT-CENTERED HEALTH EQUITY STRATEGIC PLAN AND SUSTAINABLE FUNDING

Introduced by Oklahoma, South Carolina, Mississippi

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, Our American Medical Association HOD reaffirm Policy H-180.944, “Plan for Continued Progress Toward Health Equity,” and aggressively advocate for Health Equity as defined as optimal health for all which should be the goal toward which our AMA will work by advocating for health care access, promoting equity in care, increasing health workforce diversity, influencing determinants of health, and voicing and modeling commitment to health equity; and be it further

RESOLVED, That our AMA Center for Health Equity’s future strategic plan should include advocacy planning and be presented to the AMA HOD for consideration with the opportunity for it to be more widely understood, strengthened, and supported by the HOD; and be it further

RESOLVED, As the AMA Center for Health Equity develops its next strategic plan, it shall actively engage our AMA Board of Trustees in the strategic planning process, and ensure a more patient-centered strategic plan for health equity advocacy that is consistent with the intent of AMA policies, including H-180.944, “Plan for Continued Progress Toward Health Equity,” and D-180.981, “Plan for Continued Progress Toward Health Equity,” and report the strategic plan to the HOD at the 2024 Annual Meeting prior to publicly releasing the plan to the press; and be it further

RESOLVED, That our AMA, in a collaboration with interested stakeholders, actively advocate for sustainable funding from Congress to increase health equity efforts of identifying and reducing health disparities including but not limited to funding of the Health Resources and Services Administration through U.S. Department of Health and Human Services and our AMA Health Equity Center.

607. ACCOUNTABILITY FOR ELECTION RULES VIOLATIONS

Introduced by Texas

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association empower the Election Committee to develop a list of appropriate penalties for candidates and caucus/delegation/section leadership who violate election rules; and be it further

RESOLVED, That the Election Committee define potential election rule violations as minor (oversight or misinterpretation of rules), moderate (more serious and more likely to affect the outcome of an election), and severe (intentional violation with high likelihood of affecting the outcome of an election) and assign appropriate penalties or actions to remedy the situation and/or report the violation to the House of Delegates; and be it further

RESOLVED, That any candidate who is deemed to have violated the vote trading election rule be disqualified from the current race as well as any future races at the AMA for a period not less than 2 years, upon the recommendation of the Election Committee and approval of the full House of Delegates; and be it further

RESOLVED, That any caucus/delegation/section leadership that is found to have engaged in vote trading shall not be allowed to sponsor any candidates for a period not less than 2 years; and be it further

RESOLVED, That anyone who is deemed by the Election Committee to have knowingly and egregiously violated the vote trading rule be referred to the Council on Ethical and Judicial Affairs for potential ethics violations.

RESOLUTION 608 WAS NOT CONSIDERED

REFERENCE COMMITTEE J

801. PARITY IN MILITARY REPRODUCTIVE HEALTH INSURANCE COVERAGE FOR ALL SERVICE MEMBERS AND VETERANS

Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS

See Policy H-510.984

RESOLVED, That our American Medical Association support expansion of reproductive health insurance coverage to all active-duty service members and veterans eligible for medical care regardless of service-connected disability, marital status, gender, or sexual orientation.

802. INDEPENDENT DATABASES OF ALLOWED AMOUNTS AND CHARGES
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-70.941

RESOLVED, That our American Medical Association advocate for independent, non-conflicted databases of allowed amounts and charges to ensure the continued identification of provider type and the frequency by which particular CPT codes are used; and be it further

RESOLVED, That our American Medical Association advocate that independent, non-conflicted databases of allowed amounts and charges be transparent on the source of their data, and must validate the data that they directly receive from payors for accuracy against what is actually paid to health care clinicians

803. PATIENT CENTERED MEDICAL HOME – ADMINISTRATIVE BURDENS
Introduced by New York

Considered on reaffirmation calendar

HOD ACTION: POLICY D-405.972 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek regulations which would reduce the increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on physicians and patient care.

804. CENTERS FOR MEDICARE & MEDICAID INNOVATION PROJECTS
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: 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; 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.

805. COVID VACCINE ADMINISTRATION FEE
Introduced by Utah

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED
See Policy D-440.981

RESOLVED, That American Medical Association policy D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines,” be amended by addition to read as follows:

D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines”

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician’s office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

806. HEALTHCARE MARKETPLACE PLAN SELECTION

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION 806 ADOPTED
IN LIEU OF RESOLUTION 806
See Policy D-165.933

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.

807. MEDICARE ADVANTAGE RECORD REQUESTS
Introduced by Georgia

Considered on reaffirmation calendar

HOD ACTION: POLICY H-315.987 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the relevant agencies and stakeholders to prevent Medicare Advantage plans from requesting records from practices solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise advocate that the plan will reimburse the practices for their efforts in obtaining additional requested information.

808. REINSTATEMENT OF CONSULTATION CODES
Introduced by Georgia

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: POLICY D-385.955 REAFFIRMED
IN LIEU OF RESOLUTION 808

RESOLVED, That our American Medical Association proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.

809. UNIFORMITY AND ENFORCEMENT OF MEDICARE ADVANTAGE
PLANS AND REGULATIONS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-330.878

RESOLVED, That our American Medical Association advocate for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; and be it further

RESOLVED, That our AMA advocate that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and be it further

RESOLVED, That our American Medical Association advocate that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

810. MEDICARE DRUG PRICING AND PHARMACY COSTS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: POLICIES H-105.988, H-110.987, H-125.978, D-110.994,
AND D-330.954 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for immediate, timely and transparent negotiations for how Medicare drug prices are set to be incorporated into law; and be it further

RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for current medications (commonly known as patent evergreening); and be it further

RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for prescription drugs by no later than five years, in 2027.

811. COVERING VACCINATIONS THROUGH MEDICARE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-330.896

RESOLVED, That our American Medical Association advocate that Medicare cover the full cost of all vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices (ACIP) at the point of care and outside of budget neutrality requirements.

812. COVERAGE FOR IMPLANT ASSOCIATED MALIGNANCIES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-55.968

RESOLVED, That our American Medical Association support appropriate coverage of the workup for potential cancer diagnosis, staging, locoregional treatment (e.g., surgery or radiation therapy), and other systemic treatment options for breast implant-associated anaplastic large cell lymphoma, breast implant-associated squamous cell carcinoma, and other implant-associated malignancies.

813. AMENDING POLICY ON A PUBLIC OPTION TO MAXIMIZE AMA ADVOCACY

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION 813 ADOPTED
IN LIEU OF RESOLUTION 813
See Policy H-165.823

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:

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

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.

~~1~~ 2. Our AMA will advocate that any public option to expand health insurance coverage must meet 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.

2-3. 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.
- b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
- c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
- d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
- e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
- f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
- g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
- h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

3-4. Our AMA: (a) will advocate that any federal approach to cover 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 credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

814. NATIONAL COVERAGE DETERMINATION OF CORONARY ARTERY CALCIUM SCORING”

Reference committee hearing: see report of Reference Committee J.

**HOD ACTION: ALTERNATE RESOLUTION 814 ADOPTED
 IN LIEU OF RESOLUTION 814
 See Policy D-425.991**

RESOLVED, That our American Medical Association ask the United States Preventive Services Task Force to study the impact of a national coverage determination to include coronary artery calcium scoring for patients who meet the screening criteria.

815. MODERNIZING APPROACH TO DEBT LITIGATION AGAINST PATIENTS

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION 815 NOT ADOPTED

[Editor's note: The reference committee had proposed Alternate Resolution 815 below, but it was not adopted. No further motion was made, meaning the original Resolution 815 also lapsed.]

RESOLVED, That our American Medical Association encourage health care organizations to: (1) Consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to patients' well-being; and (2) Manage medical debt with patients directly and consider several options, including assistance applying for insurance coverage, discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before initiating litigation or using third-party debt collectors.

816. COVERAGE FOR CONTINUOUS OR FLASH GLUCOSE MONITORING DEVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-480.959 and H-330.885

RESOLVED, That our American Medical Association (AMA) advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective continuous or flash glucose monitoring devices; and be it further

RESOLVED, That our American Medical Association amend Policy H-330.885 by addition and deletion to read as follows:

H-330.885, ~~Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes~~

Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring devices systems for patients with insulin-dependent diabetes when it is evidence-based and determined appropriate by physicians.

817. PROMOTING ORAL ANTICANCER DRUG PARITY

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION 817 ADOPTED
IN LIEU OF RESOLUTION 817
See Policy H-55.986

RESOLVED, That our American Medical Association work with interested stakeholders to advocate for cost-sharing parity between injectable/infusable and oral therapy for cancer.

818. PEDIATRIC OBESITY TREATMENT INSURANCE COVERAGE

Reference committee hearing: see report of Reference Committee J.

**HOD ACTION: ALTERNATE RESOLUTION 818 ADOPTED
 IN LIEU OF RESOLUTION 818
 See Policy D-440.954**

RESOLVED, That our American Medical Association amend Policy D-440.954, “Addressing Obesity,” by addition and deletion:

D-440.954, “ADDRESSING ADULT AND PEDIATRIC OBESITY”

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. That our AMA work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
- ~~3.4.~~ 4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
- ~~4 5.~~ 5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
 - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
 - Advocacy efforts at the state and federal level to impact the disease obesity.
 - Health disparities, stigma and bias affecting people with obesity.
 - Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
 - Increasing obesity rates in children, adolescents and adults.
 - Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
- ~~5 6.~~ 6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
- ~~6 7.~~ 7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 4 5. above.

**819. ADVOCATING FOR THE IMPLEMENTATION OF UPDATED U.S. PREVENTIVE SERVICES
TASK FORCE RECOMMENDATIONS FOR COLORECTAL CANCER SCREENING
AMONG PRIMARY CARE PHYSICIANS AND MAJOR PAYORS BY THE AMA**

Reference committee hearing: see report of Reference Committee J.

**HOD ACTION: ALTERNATE RESOLUTION 819 ADOPTED
IN LIEU OF RESOLUTION 819**
See Policy D-425.990

RESOLVED, That our American Medical Association coordinate with interested national medical specialty societies and state medical associations to enhance physician education and awareness of the US Preventive Services Task Force (USPSTF) guidelines to initiate preventive screening for colorectal cancer at age 45.

820. THIRD-PARTY PHARMACY BENEFIT ADMINISTRATORS

Introduced by American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Neurology, American Academy of Ophthalmology, American College of Gastroenterology, American Society of Hematology, Association for Clinical Oncology, North American Neuro-Ophthalmology Society, American Gastroenterological Association, American Contact Dermatitis Society, American Society of Dermatopathology, Florida, Iowa, Arizona, Utah, American Society for Dermatologic Surgery, American College of Mohs Surgery

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED
See Policy H-110.963

RESOLVED, That our American Medical Association recommend that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements; and be it further

RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels.

**821. PrEP IS AN ESSENTIAL HEALTH BENEFIT
Introduced by Integrated Physician Practice Section**

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-165.821

RESOLVED, That our American Medical Association supports the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as a Preventive Essential Health Benefit under the Patient Protection and Affordable Care Act; and be it further

RESOLVED, That our AMA support and join legal efforts to overturn the judgment rendered in *Braidwood v. Becerra* in the U.S. District Court for the Northern District of Texas.

822. MONITORING OF ALTERNATIVE PAYMENT MODELS WITHIN TRADITIONAL MEDICARE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association monitor the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of healthcare and patient/provider choice, and report back to the House of Delegates on the impact of the ACO-REACH demonstration program annually until its conclusion; and be it further

RESOLVED, That our AMA advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare; and be it further

RESOLVED, That our AMA develop educational materials for physicians regarding the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interests of themselves and their patients.

823. HEALTH INSURERS AND COLLECTION OF CO-PAYS AND DEDUCTIBLES
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for legislation and/or regulations to require insurers to collect co-pays and deductibles in fee-for-service arrangements directly from patients with whom the insurers are contractually engaged and pay physicians the full contracted rate unless physicians opt out to collect on their own.

**824. ENABLING AND ENHANCING THE DELIVERY OF CONTINUITY OF CARE WHEN
PHYSICIANS DELIVER CARE ACROSS DIVERSE PROBLEM SETS**
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter.

RESOLUTION 825 WAS NOT CONSIDERED

826. LEVELING THE PLAYING FIELD
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-330.902

RESOLVED, That our American Medical Association produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation; and be it further

RESOLVED, That our AMA consider disseminating the resulting educational materials and graphics.

REFERENCE COMMITTEE K

**901. OPPOSING THE USE OF VULNERABLE INCARCERATED PEOPLE IN RESPONSE
TO PUBLIC HEALTH EMERGENCIES**
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association oppose the use of forced or coercive labor practices for incarcerated populations; and be it further

RESOLVED, That our AMA support that any labor performed by incarcerated individuals or other captive populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration.

902. REDUCING THE BURDEN OF INCARCERATION ON PUBLIC HEALTH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-430.992

RESOLVED, That our American Medical Association support efforts to reduce the negative health impacts of incarceration, such as: (1) implementation and incentivization of adequate funding and resources towards indigent defense systems; (2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and (3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings; and be it further

RESOLVED, That our AMA partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, and the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals as well as research into alternatives to incarceration.

RESOLUTION 903 WAS NOT CONSIDERED

904. IMMIGRATION STATUS IS A PUBLIC HEALTH ISSUE
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-350.975

RESOLVED, That our American Medical Association declare that immigration status is a public health issue that requires a comprehensive public health response and solution; and be it further

RESOLVED, That our AMA recognize interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health; and be it

RESOLVED, That our AMA promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population; and be it further

RESOLVED, That our AMA support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

905. MINIMAL AGE OF JUVENILE JUSTICE JURISDICTION IN THE UNITED STATES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-60.919

RESOLVED, That our American Medical Association create a policy to establish minimal age of 14 years for juvenile justice jurisdiction in the United States; and be it further

RESOLVED, That our AMA develop model legislation to establish minimal age of 14 for juvenile justice jurisdiction in the United States.

906. REQUIREMENT FOR COVID-19 VACCINATION IN PUBLIC SCHOOLS
ONCE FULLY FDA AUTHORIZED
Introduced by New York

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: POLICY H-440.808 AMENDED
IN LIEU OF RESOLUTION 906
See Policy H-440.808

RESOLVED, That Policy H-440.808, "Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19," be amended by addition to read as follows:

COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials:

- a. vaccine is widely accessible;
- b. equity-centered privacy protections are in place to safeguard data collected from individuals;
- c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and

- d. credentials address the situation of individuals for whom vaccine is medically contraindicated.
2. Recommends that decisions to mandate COVID-19 vaccination, including, but not limited to for school attendance for children and college/university students, be made only:
 - a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
 - b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
 - c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
 - d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.
3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust.

**907. A NATIONAL STRATEGY FOR COLLABORATIVE ENGAGEMENT, STUDY, AND SOLUTIONS
TO REDUCE THE ROLE OF ILLEGALLY POSSESSED FIREARMS IN FIREARM RELATED INJURY**
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee K.

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

See Policy H-145.975, H-145.984, H-145.997, D-145.994, and D-145.999

RESOLVED, That our American Medical Association support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States; and be it further

RESOLVED, That our AMA work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies, to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms; and be it further

RESOLVED, That our AMA 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 firearms in our firearm injury public health crisis; and be it further

RESOLVED, That our AMA reaffirm House Policies H-145.975, H-145.984, H-145.997, D-145.994, and D-145.999 calling for increased funding for national firearm violence research.

908. OLDER ADULTS AND THE 988 SUICIDE AND CRISIS LIFELINE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee K.

**HOD ACTION: POLICY D-345.974 AMENDED
 IN LIEU OF RESOLUTION 908**

RESOLVED, That Policy D-345.974, “Awareness Campaign for 988 National Suicide Prevention Lifeline” be amended by addition and deletion to read as follows:

Our AMA will: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system, including the development

of model legislation; and (3) collaborate with the Substance Abuse and Mental Health Services Administration, and the 9-8-8 partner community, and other interested stakeholders, to strengthen suicide prevention and mental health crisis services that prioritize education and outreach to those populations at highest risk for suicide attempts, suicide completions, and self-injurious behavior.

**909. DECREASING FIREARM VIOLENCE AND SUICIDE IN SENIORS
AND OTHER HIGH-RISK POPULATIONS
Introduced by Senior Physicians Section**

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-145.975

RESOLVED, That our American Medical Association and other organizations develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations; and be it further

RESOLVED, That our AMA develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states; and be it further

RESOLVED, That our AMA partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.

**910. GONAD SHIELDS: REGULATORY AND LEGISLATION ADVOCACY
TO OPPOSE ROUTINE USE
Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-480.958

RESOLVED, That our American Medical Association oppose mandatory use of patient gonad shields in medical imaging considering the risks far outweigh the benefits; and be it further

RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the code of federal regulations to oppose the routine use of patient gonad shields in medical imaging; and be it further

RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of patient gonad shields in medical imaging.

911. CRITICAL NEED FOR NATIONAL EMERGENCY CARDIAC CARE (ECC) SYSTEM TO ENSURE INDIVIDUALIZED, STATE-WIDE, CARE FOR ST SEGMENT ELEVATION MYOCARDIAL INFARCTION (STEMI), CARDIOGENIC SHOCK (CS) AND OUT-OF-HOSPITAL CARDIAC ARREST (OHCA), AND TO REDUCE DISPARITIES IN HEALTH CARE FOR PATIENTS WITH CARDIAC EMERGENCIES

Introduced by Society for Cardiovascular Angiography & Interventions, Georgia

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS`

See Policy D-160.946

RESOLVED, That our American Medical Association encourage the standardization of pre-hospital and in-hospital care for cardiac emergencies, to improve care and enhance survival for all patients, especially for those who receive socioeconomically, geographically, and demographically disparate care, when they present with ST Elevation Myocardial Infarction (STEMI), STEMI with cardiogenic shock (STEMI-CS), and Out of Hospital Cardiac Arrest (OHCA); and be it further

RESOLVED, That our AMA encourages regional or national hospital designation or categorization systems for Emergency Cardiac Care Centers based on their individual capabilities to provide ECC, analogous to hospital designations or categorizations and systems of care for stroke and trauma.

912. REEVALUATING THE FOOD AND DRUG ADMINISTRATION'S CITIZEN PETITION PROCESS

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ALTERNATE RESOLUTION 912 ADOPTED IN LIEU OF RESOLUTION 912

See Policy D-100.965

RESOLVED, That our AMA work with relevant stakeholders to advocate for further public transparency of citizen petitions to the Food and Drug Administration, including the relationship between citizen petitions and decisions to delay generic approval, conflicts of interest to be disclosed, and the time and resources expended on petition reviews.

913. SUPPORTING AND FUNDING SOBERING CENTERS

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association recognize the utility, cost effectiveness, and racial justice impact of sobering centers; and be it further

RESOLVED, That our AMA support the maintenance and expansion of sobering centers; and be it further

RESOLVED, That our AMA support ongoing research of the sobering center public health model; and be it further

RESOLVED, That our AMA support the use of state and national funding for the development and maintenance of sobering centers.

RESOLUTION 914 WAS NOT CONSIDERED

915. PULSE OXIMETRY IN PATIENTS WITH PIGMENTED SKIN
Introduced by Washington

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-480.957

RESOLVED, That our American Medical Association recognizes that pulse oximeters may not accurately measure oxygen saturation in all skin tones and will continue to urge the US Food and Drug Administration to 1) ensure pulse oximeters provide accurate and reliable readings for patients with diverse degrees of skin pigmentation and 2) ensure health care personnel and the public are educated on the limitations of pulse oximeter technology so they can account for measurement error.

916. HPV-ASSOCIATED CANCER PREVENTION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-440.872

RESOLVED, That our American Medical Association amend Policy H-440.872, “HPV Vaccine and Cervical Cancer Prevention Worldwide,” by addition and deletion to read as follows:

H-440.872, “HPV Vaccine and Routine HPV-Related ~~Cervical~~ Cancer Prevention Worldwide”

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV-related ~~cervical~~ cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV-related ~~cervical~~ cancer screening in countries without organized HPV-related ~~cervical~~ cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in all individuals regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV-related ~~cervical~~ cancer screening in the general public.
3. Our AMA:
 - a. encourages the integration of HPV vaccination and routine HPV-related ~~cervical~~ cancer screening into all appropriate health care settings and visits ~~for adolescents and young adults,~~
 - b. supports the availability of the HPV vaccine and routine HPV-related ~~cervical~~ cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations,
 - c. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings and be it further

RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers; and be it further

RESOLVED, That our AMA study requiring HPV vaccination for school attendance.

917. CARE FOR CHILDREN WITH OBESITY
Introduced by Society of American Gastrointestinal and Endoscopic Surgeons

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association actively support the education of physicians on the morbidity of childhood obesity, the existence of effective treatment for this condition, and the importance of patients obtaining bariatric care as early as possible; and be it further

RESOLVED, That our AMA support the development of multidisciplinary care programs for children with obesity, inclusive of bariatric surgery care, access to medications, nutrition, and mental health support; and be it further

RESOLVED, That our AMA actively work to remove barriers to bariatric surgery, access to medications, nutrition, and mental health support for the treatment of obesity in children.

918. OPPOSITION TO ALCOHOL INDUSTRY MARKETING SELF-REGULATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-30.940

RESOLVED, That our American Medical Association amend Policy H-30.940, “Labeling Advertising, and Promotion of Alcoholic Beverages,” by addition and deletion to read as follows:

H-30.940, “Labeling, Advertising, and Promotion of Alcoholic Beverages”

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called “nonalcoholic” beer and other substances as well, including over-the-counter and prescription medications, with removal of “nonalcoholic” from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called “nonalcoholic” beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of “nonalcoholic beer” by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports federal and/or state oversight for all forms of alcohol advertising in lieu of the alcohol industry’s current practice of self-regulated advertising and marketing; ~~(a)(b)~~ supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; ~~(b)(c)~~ opposes the use of the radio and television any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(e)(d)~~ will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)(e)~~ urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and ~~(e)(f)~~ urges its constituent state associations to support

state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

919. DECREASING YOUTH ACCESS TO E-CIGARETTES **Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association support the inclusion of disposable and tank-based e-cigarettes in the language and implementation of any restrictions that are applied by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes; and be it further

RESOLVED, That AMA Policy H-495.986, “Tobacco Product Sales and Distribution,” be amended by addition to read as follows:

H-495.986, “Tobacco Product Sales and Distribution”

Our AMA:

- (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
- (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
- (3) supports the development of model legislation regarding enforcement of laws restricting children’s access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children’s access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales (“loosies”); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
- (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
- (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
- (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
- (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
- (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and

- (9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.
(11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and
(12) support measures that decrease the overall density of tobacco specialty stores, including but not limited to, preventing retailers from opening new tobacco specialty stores in proximity to existing tobacco specialty stores.

RESOLUTION 920 WAS WITHDRAWN

921. FIREARM INJURY AND DEATH RESEARCH AND PREVENTION **Introduced by American Academy of Pediatrics**

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS

See Policy D-145.994, D-145.995, H-145.997, and D-145.999

RESOLVED, That Policy D-145.999, “Epidemiology of Firearm Injuries” be amended by addition and deletion to read as follows:

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; ~~and~~ (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms, and (3) advocate for improvements to the quality, comparability, and timeliness of data on firearm injuries and deaths.

and be it further

RESOLVED, That our AMA advocate for repeal of laws which prohibit the release of firearm tracing data for research; and be it further

RESOLVED, That Policies D-145.994, “Removing Restrictions on Federal Funding for Firearm Violence Research,” D-145.995, “Gun Violence as a Public Health Crisis,” and H-145.997, “Firearms as a Public Health Problem in the United States - Injuries and Death” be reaffirmed.

922. FIREARM SAFETY AND TECHNOLOGY **Introduced by American Academy of Pediatrics**

Considered on reaffirmation calendar

HOD ACTION: POLICIES H-145.985 AND H-145.997 REAFFIRMED **IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, That our American Medical Association solicit technology company interest in and advocate for the design of affordable personalized “smart” gun and safety technology which allow only authorized users to pull the trigger on the firearm.

923. PHYSICIAN EDUCATION AND INTERVENTION TO IMPROVE PATIENT FIREARM SAFETY
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
ADDITIONAL RESOLVE REFERRED
See Policy H-145.990

RESOLVED, That our American Medical Association and all interested medical societies educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; and be it further

RESOLVED, That our AMA and all interested medical societies educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home; and be it further

RESOLVED, That our AMA and all interested medical societies educate the public about: (1) best practices for firearm storage safety; (2) misconceptions families have regarding child response to encountering a firearm in the home; and (3) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

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

RESOLVED, That our AMA and all interested medical societies advocate for policies that support the provision of funding for physicians to provide affordable rapid-access safe storage devices to patients with firearms in the home.

924. DOMESTIC PRODUCTION OF PERSONAL PROTECTIVE EQUIPMENT
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-440.847

RESOLVED, That our American Medical Association encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States; and be it further

RESOLVED, That our AMA support federal efforts to encourage the purchase of domestically produced personal protective equipment; and be it further

RESOLVED, That our AMA reaffirm Policy H-440.847, "Pandemic Preparedness."

RESOLUTION 925 WAS NOT CONSIDERED

926. LIMIT THE PORNOGRAPHY VIEWING BY MINORS OVER THE INTERNET
Introduced by Michigan

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-60.934

RESOLVED, That our American Medical Association amend existing Policy H-60.934, “Internet Pornography Protecting Children and Youth Who Use the Internet and Social Media,” by addition to read as follows:

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
- (2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
- (3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
- (4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
- (5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
- (6) Actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.

927. OFF-LABEL POLICY
Introduced by Michigan

Considered on reaffirmation calendar

HOD ACTION: POLICY H-120.988 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association amend Policy H-120.988, “Patient Access to Treatments Prescribed by Their Physicians,” by addition to read as follows:

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate ‘off-label’ uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).

5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.
7. Our AMA supports physician autonomy with regard to deciding appropriate dosing.

**928. EXPANDING TRANSPLANT EVALUATION CRITERIA TO INCLUDE PATIENTS THAT MAY
NOT SATISFY CENTER-SPECIFIC SOBRIETY REQUIREMENTS
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee K.

**HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-370.955**

RESOLVED, That our American Medical Association encourage transplant centers to consider evaluation of patients who may not satisfy center-specific sobriety requirements on a case-by-case basis, using medically appropriate criteria.

**929. OPPOSING THE MARKETING OF PHARMACEUTICALS TO PARTIES
RESPONSIBLE FOR CAPTIVE POPULATIONS
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee K.

**HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-100.964**

RESOLVED, That our American Medical Association oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations; and be it further

RESOLVED, That our AMA advocate for the inclusion of physicians and pharmacists in the selection of medications available to captive populations such as incarcerated individuals; and be it further

RESOLVED, That our AMA support and work with state medical societies to support measures to increase transparency in medication procurement, including but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (2) centralizing formulary choices in a physician-led office, agency, or commission following the principles of a sound formulary.

930. ADDRESSING LONGITUDINAL HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE

Reference committee hearing: see report of Reference Committee K.

**HOD ACTION: ALTERNATE RESOLUTION 930 ADOPTED
IN LIEU OF RESOLUTION 930
See Policy D-350.977**

RESOLVED, That our AMA support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and health care professionals; and be it further

RESOLVED, That our AMA advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care, including to ensure the provision of continuity of care for children who are at the age of transition out of foster care; and be it further

RESOLVED, That our AMA advocate for oversight of local, tribal, and state child welfare systems by physicians with expertise in pediatrics and child psychiatry; and be it further

RESOLVED, That our AMA promote existing medical homes which provide continuity of care to children in foster care when feasible; and be it further

RESOLVED, That our AMA support the appointment of a licensed pediatrician or family medicine physician (with substantial pediatric experience) in each state with experience in child welfare to the position of medical director of child welfare and a psychiatrist with substantial child and adolescent psychiatric experience to the position of psychiatric medical director of child welfare for each Title IV-E agency; and be it further

RESOLVED, That Policy D-350.977, “Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care” be reaffirmed.

**931. AMENDING H-160.903 ERADICATING HOMELESSNESS TO INCLUDE SUPPORT
FOR STREET MEDICINE PROGRAMS
Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.903

RESOLVED, That our American Medical Association encourage medical schools to implement physician-led, team-based street medicine programs with student involvement; and be it further

RESOLVED, That our AMA recognizes and supports the use of street medicine programs by amending Policy H-160.903, Eradicating Homelessness by addition and deletion to read as follows:

H-160.903, “Eradicating Homelessness”

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
- ~~(4)~~ recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- ~~(5)~~ encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- ~~(6)~~ will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
- ~~(7)~~ encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- ~~(8)~~ encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- ~~(9)~~ (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and

(~~1011~~) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; ~~and~~ (~~1112~~) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

RESOLUTION 932 WAS NOT CONSIDERED

933. REDUCING DISPARITIES IN HIV INCIDENCE THROUGH PRE-EXPOSURE PROPHYLAXIS (PREP) FOR HIV Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-20.895

RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre Exposure Prophylaxis (PrEP) for HIV” by addition to read as follows:

H-20.895, “Pre-Exposure Prophylaxis (PrEP) for HIV”

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers, that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling.

RESOLUTION 934 WAS NOT CONSIDERED

935. GOVERNMENT MANUFACTURING OF GENERIC DRUGS TO ADDRESS MARKET FAILURES Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **REFERRED**

RESOLVED, That our American Medical Association support the formation of a non-profit government manufacturer of pharmaceuticals to produce small-market generic drugs.

936. PROMOTING THE USE OF MULTI-USE DEVICES AND SUSTAINABLE PRACTICES IN THE OPERATING ROOM**Introduced by Medical Student Section***Reference committee hearing: see report of Reference Committee K.***HOD ACTION: REFERRED
POLICY H-480.959 REAFFIRMED**

RESOLVED, That Policy H-480.959 be reaffirmed.

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

RESOLVED, That our American Medical Association advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.

937. INDICATIONS FOR METABOLIC AND BARIATRIC SURGERY**Introduced by American Society for Metabolic and Bariatric Surgery,
Society of American Gastrointestinal and Endoscopic Surgeons***Reference committee hearing: see report of Reference Committee K.***HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association acknowledge and accept the new American Society for Metabolic and Bariatric Surgery and International Federation for the Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery; and be it further

RESOLVED That our AMA immediately call for full acceptance of these guidelines by insurance providers, hospital systems, policy makers, and government healthcare delivery entities; and be it further

RESOLVED, That our AMA work with all interested parties to lobby the legislative and executive branches of government to affect public health insurance coverage to ensure alignment with these new guidelines.

938. AMA STUDY OF EFFICACY OF REQUIREMENTS FOR METAL DETECTION/WEAPONS INTERDICTION SYSTEMS IN HEALTH CARE FACILITIES**Introduced by Academic Physicians Section***Reference committee hearing: see report of Reference Committee K.***HOD ACTION: REFERRED**

RESOLVED, That our American Medical Association Council on Science and Public Health study the issues of 1) workplace violence as it impacts health care workers, patients, and visitors, and 2) anticipated positive impacts of weapons detection and interdiction systems toward reduction of workplace violence, so that our AMA can develop learned and data-based recommendations and accompanying advocacy regarding proposed new requirements for the deployment of these systems in health care settings, and share these recommendations with accrediting bodies such as The Joint Commission, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other relevant stakeholders, including the American Hospital Association.

RESOLUTION 939 WAS NOT CONSIDERED