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

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

| **Cmte\*** | **Item** | **Sponsor†** | **Title** | **Recommendations or Resolves** |
| --- | --- | --- | --- | --- |
| .Con | BOT 01 | n/a | Employed Physicians | Recommendation  The Board of Trustees recommends that the following recommendation be adopted in lieu of the recommendations of BOT Report 09-I-22 and that the remainder of this report be filed:  That our AMA re-examine the representation of employed physicians within the organization and report back at the 2024 Annual Meeting. |
| .Con | BOT 10 | n/a | Medical Decision-Making Autonomy of the Attending Physician | RECOMMENDATION  In light of the foregoing, your Board of Trustees recommends that the:   1. First, second, and third resolve clauses of Resolution 009, “Medical Decision-Making Autonomy of the Attending Physician” not be adopted; and 2. Fourth resolve clause of Resolution 009 be adopted with amendment as follows:   That our AMA ~~aggressively pursue~~ continue to strongly oppose any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients ~~as strongly as possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm~~. (Directive to Take Action) |
| .Con | CEJA 1 | n/a | Physicians’ Use of Social Media for Product Promotion and Compensation | RECOMMENDATION  In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that:  Opinion 9.6.4, “Sale of Health-Related Products,” and Opinion 9.6.5, “Sale of Non-Health-Related Products” be consolidated and amended by substitution to read as follows:  The sale or promotion of products or services by physicians may offer benefit to patients or the public but may also conflict with their professional ethical responsibilities. Whether intended or not, they may be perceived to use their professional knowledge and stature as inducements to consumers. There are four key scenarios of sales or promotion: (1) health-related products or services marketed to patients, (2) health-related products or services marketed to the general public, (3) non-health-related product or services marketed to patients, and (4) non-health-related products or services marketed to the general public.  Of greatest concern are commercial practices in which physicians sell or promote goods or services to patients. In these circumstances patients may feel pressured to purchase the product or service, which may compromise the physician’s fiduciary obligation to put patients’ interests above their own financial interests and undermine the trust that grounds patient-physician relationships. Similarly, if physicians lend their credibility as medical professionals to products or services that are not supported by peer-reviewed evidence or are of questionable value they may put patient well-being and the integrity of the profession in jeopardy.  Physicians and medical students therefore should:  Refrain from leveraging their professional role to promote unrelated business ventures.  Fully disclose the nature of their financial interest in the product or service.  Avoid exclusive distributorship arrangements that make products or services available only through the individual’s commercial venue.  Limit the sale or promotion of health-related goods or services only to those that serve the immediate needs of patients and strive to make the product or service available at a reasonable cost.  Refrain from the sale or promotion of non-health-related goods or services as a regular part of their professional activities. (Modify HOD/CEJA Policy); and  2. Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as follows:  Social media—internet-enabled communication technologies—enable individual medical students and physicians to have both a personal and a professional presence online. Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to disseminate public health messages and other health communication widely. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.  Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:  Use caution when publishing any content that could damage their individual professional reputation or impugn the integrity of the profession.  (b) Respect professional standards of patient privacy and confidentiality and refrain from publishing identifiable patient information online. When they use social media for educational purposes or to exchange information professionally with other physicians or medical students they should follow ethics guidance regarding confidentiality, privacy, and informed consent.  (c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with patients through social media, just as they would in any other context.  (d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.  Disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.  (f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate. They should likewise ensure to the best of their ability that non-health-related information is not deceptive. (Modify HOD/CEJA Policy); and  3. The remainder of this report be filed. |
| .Con | CEJA 2 | n/a | Research Handling of De-Identified Patient Data | RECOMMENDATIONS  In light of the challenges considered with regard to constructing a framework for holding stakeholders accountable within digital health information ecosystems, the Council on Ethical and Judicial Affairs recommends:  1. That the following be adopted:  Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health.  When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession’s responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.  As members of health care institutions, physicians should:   1. Follow existing and emerging regulatory safety measures to protect patient privacy; 2. Practice good data intake, including collecting patient data equitably to reduce bias in datasets; 3. Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with HIPAA (or current legal standards).   Health care systems, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:   1. The high value that health care institutions place on protecting patient data; 2. The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist; 3. How patient data may be used and by whom; 4. The importance of de-identified aggregated data for improving the care of future patients.   Health care systems, as health data stewards, should:   1. Establish appropriate data collection methods and practices that meet industry standards to ensure the creation of high-quality datasets; 2. Ensure proper oversight of patient data is in place, including provisions for the use of de-identified datasets that may be shared, sold, or resold; 3. Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review boards free of conflicts of interest to evaluate the sale and potential resale of clinically-derived datasets; 4. Take appropriate cyber security measures to ensure the highest level of protection is provided to patients and patient data; 5. Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients; 6. Advocate that health- and non-health entities using any health data adopt the strongest protections and uphold the ethical values of the medical profession.   There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients’ express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and  2. That Opinion 2.1.1, “Informed Consent”; Opinion 3.1.1, “Privacy in Health Care”; Opinion 3.2.4, “Access to Medical Records by Data Collection Companies”; and Opinion 3.3.2, “Confidentiality and Electronic Medical Records” be amended by addition as follows:  a. Opinion 2.1.1, Informed Consent  Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all options of treatment is critical to establishing trust and should extend to discussions regarding who has access to patients’ health data and how data may be used.  The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:  (a) Assess the patient’s ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.  (b) Present relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information. The physician should include information about:  (i) the diagnosis (when known);  (ii) the nature and purpose of recommended interventions;  (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.  (c) Document the informed consent conversation and the patient’s (or surrogate’s) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.  In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient’s surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)  b. Opinion 3.1.1, Privacy in Health Care  Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.  Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).  Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:  (a) Minimize intrusion on privacy when the patient’s privacy must be balanced against other factors.  (b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.  (c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.  (d) Be transparent that privacy safeguards for patient data are in place but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)  c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies  Information contained in patients’ medical records about physicians’ prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians’ treatment recommendations, such as pharmaceutical or medical device companies.  Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.  Physicians who propose to permit third-party access to specific patient information for commercial purposes should:  (a) Only provide data that has been de-identified.  (b) Fully inform each patient whose record would be involved (or the patient’s authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.  Physicians who propose to permit third parties to access the patient’s full medical record should:  (c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient’s medical record.  (d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.  (e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.  Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to ensure that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)  d. Opinion 3.3.2, Confidentiality and Electronic Medical Records  Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.  Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:  (a) Choose a system that conforms to acceptable industry practices and standards with respect to:  (i) restriction of data entry and access to authorized personnel;  (ii) capacity to routinely monitor/audit access to records;  (iii) measures to ensure data security and integrity; and  (iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.  (b) Describe how the confidentiality and integrity of information is protected if the patient requests.  (c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and  3. That the remainder of this report be filed. |
| .Con | Res. 001 | American College of Cardiology | Physician-Patient Communications in the Digital Era | RESOLVED, that our American Medical Association conduct a comprehensive study defining the appropriate role of digital interaction between patients and their doctors, including models for compensation. (Directive to Take Action) |
| .Con | Res. 002 | Medical Student Section | Support for International Aid for Reproductive Healthcare | RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care (New HOD Policy)  RESOLVED, that our AMA supports global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care. (New HOD Policy) |
| .Con | Res. 003 | Medical Student Section | Guardianship and Conservatorship Reform | RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy)  RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life. (Directive to Take Action) |
| .Con | Res. 004 | Medical Student Section | Reconsideration of Medical Aid in Dying (MAID) | RESOLVED, that our AMA use the term “medical aid in dying” instead of the term “physician-assisted suicide” and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions (New HOD Policy)  RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 “Physician-Assisted Suicide” and H-140.952 “Physician Assisted Suicide,” while retaining our Code of Medical Ethics opinion on this issue (Rescind HOD Policy)  RESOLVED, that our AMA amend H-140.966 “Decisions Near the End of Life” by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:  Decisions Near the End of Life, H-140.966  Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.  (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.  (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.  ~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~  (5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)  RESOLVED, that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal. (Directive to Take Action) |
| .Con | Res. 005 | Resident and Fellow Section | Adopting a Neutral Stance on Medical Aid in Dying | RESOLVED, that our American Medical Association adopt a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter. (New HOD Policy) |
| .Con | Res. 006 | Medical Student Section | Inappropriate Use of Health Records in Criminal Proceedings | RESOLVED, that our American Medical Association encourage collaboration with relevant parties, including state and county medical societies, the American College of Correctional Physicians, and the American Bar Association, on efforts to preserve patients’ rights to privacy regarding medical care while incarcerated while ensuring appropriate use of medical records in parole and other legal proceedings to protect incarcerated individuals from punitive actions related to their medical care. (New HOD Policy) |
| .Con | Res. 007 | Medical Student Section | Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers | RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum (New HOD Policy)  RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative. (New HOD Policy) |
| .Con | Res. 008 | California | AMA Executive Vice President | RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties and Privileges Code B-5.3.6.4: ~~No individual who has served as an AMA officer or trustee shall be selected or serve as Executive Vice President until three years following completion of the term of the AMA office.”~~ (Modify Bylaws) |
| .Con | Res.009 | Academic Physicians Section | Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests | RESOLVED, that our American Medical Association advocate to appropriate credentialing organizations and payers—including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of health care goods and services—that misdemeanor or felony arrests of physicians as a result of exercising their First Amendment rights of protest through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action) |
| .Con | Speakers’ Report 03 | n/a | Report of the Election Task Force 2 | RECOMMENDATIONS  *Stickers, Buttons, and Pins*  Recommendation 1:  Policy G-610.020, Rules for AMA Elections, paragraph 18 be amended by addition and deletion to read as follows:  (18) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMA, AMPAC, the AMA Foundation, and health related causes as approved by the Speaker no less than 30 days prior the Opening Session of the House of Delegates. ~~s~~Specialty society~~ies~~, state and regional delegation~~s and health related causes~~ pins that do not include any candidate identifier may only be worn by members of the designated group. ~~These~~ All pins should be small, and may not be worn on the badge ~~and distributed only to members of the designated group~~. ~~General distribution~~ No other ~~of any~~ pin, button or sticker is ~~dis~~allowed. (Modify Current HOD Policy)  *Campaign Receptions*  Recommendation 2:  Policy D-610.998, Election Task Force, paragraph 1 be amended by addition and deletion to read as follows:   1. Our AMA will ~~investigate the feasibility of a two- (2) year trial of~~ sponsor~~ing a welcome~~ the AMA Candidate R~~r~~eception which will be open to all candidates and all meeting attendees. Any candidate may elect to be “featured” at the AMA Candidate R~~r~~eception. There will not be a receiving line at the AMA Candidate R~~r~~eception. ~~Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current~~ The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception ~~(the AMA reception or another)~~ will apply to the AMA Candidate Reception. ~~would remain~~. ~~The Speakers will report back to the House after the two-year trial with a recommendation for possible continuation of the AMA reception.~~ (Modify Current HOD Policy)   *Dinners, Suites and Such*  Recommendation 3:  An announced candidate in a currently contested election may not be “featured” at any gathering of delegates outside of the single campaign reception they have chosen. For the purpose of AMA elections, the definition of “featured” includes being mentioned in the invitation, whether written or verbal, or publicly acknowledging or discussing a candidacy with attendees at a function. (New HOD Policy)  Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 19 be amended by addition and deletion to read as follows:  19) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, and other formal campaign activities ~~and the distribution of campaign literature and gifts~~ are prohibited. ~~It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate’s opinions and positions on issues.~~ Candidates may participate in meals provided by groups of which they are a member, such as a delegation or caucus breakfast/lunch, when the meal has other purposes and does not include campaigning by the candidate or campaign team. (Modify Current HOD Policy)  Recommendation 5:  Policy G-610.020, Rules for AMA Elections, paragraph 21 be amended by deletion to read as follows:  21) Group dinners, if attended by an announced candidate in a currently contested election, must be “Dutch treat” - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. ~~Gatherings of 4 or fewer delegates or alternates are exempt from this rule.~~ (Modify Current HOD Policy)  Recommendation 6:  Only an announced candidate in a currently contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy including members of campaign teams, delegations or caucuses, and “friends.” (New HOD Policy)  *Campaign Literature*  *Electronic Communications*  *Website and Social Media*  Recommendation 7:  Policy G-610.020, Rules for AMA Elections, paragraph 15 be amended by addition and deletion to read as follows:  15) Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the Candidate Web Pages. ~~by postal mail or its equivalent~~. The AMA Office of House of Delegates Affairs will not ~~longer~~ furnish a file containing the names and mailing addresses of members of the AMA-HOD. ~~Printed campaign materials will not be included in the “Not for Official Business” bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials~~. (Modify Current HOD Policy)  Recommendation 8:  Policy G-610.020, Rules for AMA Elections, paragraph 16 be amended by addition and deletion to read as follows:  16) Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. ~~A reduction in the volume of telephone calls and~~ Personal electronic communication and telephone calls from candidates and on behalf of candidates is discouraged~~encouraged~~. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of e~~Electronic messages ~~to contact electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages. (Modify Current HOD Policy)  *Interviews*  Recommendation 9:  Policy G-610.020, Rules for AMA Elections, paragraph 11 be amended by addition and deletion to read as follows:  (11) ~~The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).~~ Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual’s contact information to the Office of House of Delegates Affairs. The Speaker’s Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups ~~as requested~~. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker. (Modify Current HOD Policy)  Recommendation 10:  Policy G-610.020, Rules for AMA Elections, paragraph 12 be amended by addition and renumbered to read as follows:  f. Recording of interviews is allowed only with the knowledge and consent of the candidate.  g. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.  ~~g~~h. Recordings of interviews may be shared only among members of the group conducting the interview.  (Modify Current HOD Policy)  Recommendation 11:  Any formal questioning of an announced candidate, including a written questionnaire, is an interview and subject to the rules for virtual interviews. (New HOD Policy)  Recommendation 12:  Any “presentation” to an assembly, with or without being followed by a discussion, question and answer session, or a vote of the assembly, is an interview and subject to the rules on in-person interviews. (New HOD Policy)  *Voting Process and Election Session*  Recommendation 13:  That Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for elections of officers and councils with multiple candidates so that the lowest vote getter on each ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in which case both would be dropped. (Directive to take Action)  Recommendation 14:  Policy D-610.998, “Directives from the Election Task Force,” paragraph 4 be amended by addition and deletion to read as follows:  4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced. If adequate time remains on the agenda when the business session reconvenes after lunch on the day that the Election Session was held, the Speaker is encouraged to allow candidate personal points from the floor confined to the current time limit for testimony. ~~including collecting w~~Written personal points from candidates should be sent to the HOD office within 10 days following the close of the meeting to be shared electronically with the House ~~after the meeting or imposing time limits on such comments~~. (Modify Current HOD Policy)  *Announcements and Nomination*  Recommendation 15:  Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition and deletion to read as follows:  2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker’s office with an electronic announcement “card” that includes any or all of the following elements and no more: the candidate’s name, photograph, email address, ~~URL,~~ the office sought and a list of up to four (4) endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed ~~in the venue where the House of Delegates meets. Announcements sent by candidates~~ to members of the House by any method. ~~are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.~~ (Modify Current HOD Policy)  Recommendation 16:  Candidates may not produce a personal campaign website or direct to personal or professional websites other than the AMA Candidates’ Page. (New HOD Policy)  Recommendation 17:  Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:  (3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an “Official Candidate Notification” will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker’s notice of the opening of active campaigning which generally follows~~ing~~ the April Board meeting ~~and on “Official Announcement Dates” to be established by the Speaker~~. (Modify Current HOD Policy)  Recommendation 18:  Policy G-610.020, Rules for AMA Elections, paragraph 10, be amended by addition and deletion to read as follows:  (10) Active campaigning for AMA elective office may not begin until the Speaker so notifies the House, which is generally after the April Board of Trustees~~, after its April~~ meeting.~~, announce the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~ (Modify Current HOD Policy)  Recommendation 19:  Policy G-610.020, Rules for AMA Elections, paragraph 25, be amended by addition and deletion to read as follows:  (25) Our AMA ~~(a)~~ requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election.~~; and~~ Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. ~~(b) will expand accessibility to completed conflict of interest information~~ The HOD Office will ~~by~~ post~~ing~~ such information on the “Members Only” section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents. (Modify Current HOD Policy)  Recommendation 20:  Policy G-610.010, Rules for AMA Elections, paragraphs 3 and 4, be rescinded:  (3) the date for submission of applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year;  (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; and  Recommendation 21:  That the language in Bylaw 6.8.1, “Nomination and Election” be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place. (Directive to Take Action)  *Election Committee*  Recommendation 22:  Policy D-610.998, “Directives from the Election Task Force,” paragraph 7 be amended by addition to read as follows:  7. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates. a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation. b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process. c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House. d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties. e. Deliberations of the Election Committee shall be confidential. f. The Speaker shall include a summary of the Election Committee’s activities in “Official Candidate Notifications” sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.  (Modify Current HOD Policy)  Recommendation 23:  Candidates and their identified members of campaign teams will be provided a copy of the current election rules and will be required to attest to abiding by them. (New HOD Policy)  Recommendation 24:  Candidates, members of their campaign teams, including Federation staff, and HOD members will agree to be interviewed by the Speakers or members of the Election Committee who will identify themselves and the reason for the request. (New HOD Policy)  Recommendation 25:  Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” be amended by addition and deletion to read as follows:  Definition  Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of ~~his/her~~ race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.  Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.  Harassing conduct also includes intimidation of participating individuals by a threat of consequences in order to compel actions by individuals or a group of individuals such as casting a particular vote. (Modify Current HOD Policy)  Recommendation 26:  That our AMA consider developing bylaw language regarding removal of elected individuals and the criteria by which this would be accomplished and to report back at A-24. (New HOD Policy)  *Endorsements*  Recommendation 27:  A maximum of four endorsements may be obtained by each candidate. These endorsements must be from organizations in which the candidate is an active and dues paying member, where applicable. Endorsements may only be obtained from a candidate’s state and one specialty organization and from caucuses in which the endorsing state or specialty society is a current member. Endorsements may not be obtained from the AMA Sections, Advisory Committees, or the Specialty and Service Society. (New HOD Policy)  Recommendation 28:  Policy D-610.998, “Directives from the Election Task Force,” paragraph 10 & 11 be rescinded.  10. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speaker’s discretion the appointment of another election task force, with a report back to the House.  11. Amended Policy D-610.998 will be widely communicated, including being published in the Election Manual.  Recommendation 29:  That policies G-610.010, Nominations; G-610.020, Rules for AMA Elections; G-610.021, Guiding Principles for House Elections; G-610.030, Election Process; and D-610.998, Election Task Force as amended, be combined into one policy entitled, “AMA Election Rules and Guiding Principles,” and that this newly formed policy be widely distributed to the House and included in the Election Manual. (Directive to Take Action |
| B | BOT 06 | n/a | Universal Good Samaritan Statute | RECOMMENDATION  The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 214-I-22 and that the remainder of the report be filed.  That Policy H-130.937, Delivery of Health Care by Good Samaritans be amended by addition:  5. Our AMA will develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care. (Modify Current HOD Policy) |
| B | BOT 07 | n/a | Obtaining Professional Recognition for Medical Service Professionals | RECOMMENDATION    The Board of Trustees recommends that Alternate Resolution 232-I-22 be adopted to read as follows, and the remainder of the report be filed:  RESOLVED, That our American Medical Association support a unique standard occupational classification from the U.S. Bureau of Labor Statistics for medical services professionals. (New HOD Policy) |
| B | Res. 201 | American Association for Geriatric Psychiatry | Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care | RESOLVED, that our American Medical Association work with key partners to advocate that CMS revise the existing measure for psychotropic prescribing in nursing homes to ensure nursing home residents have access to all medically appropriate care (Directive to Take Action)  RESOLVED, that our AMA amend policy H-160.954 by insertion as follows:  (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law.  (2) Henceforth our AMA opposes any future legislation which gives the federal,  state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy) |
| B | Res. 202 | Medical Student Section | Protecting the Health of Patients Incarcerated in For-Profit Prisons | RESOLVED, that our American Medical Association advocate against the use of for-profit prisons (Directive to Take Action)  RESOLVED, that our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of healthcare. (Directive to Take Action) |
| B | Res. 203 | Medical Student Section | Anti-Discrimination Protections for Housing Vouchers | RESOLVED, that our American Medical Association support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income (New HOD Policy)    RESOLVED, that our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance. (New HOD Policy) |
| B | Res. 204 | Medical Student Section | Improving PrEP & PEP Access | RESOLVED, that our American Medical Association support efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements with physicians. (New HOD Policy) |
| B | Res. 205 | Oklahoma | Cannabis Product Safety | RESOLVED, that our American Medical Association draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding Women that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding. (Directive to Take Action) |
| B | Res. 206 | American Academy of Ophthalmology | The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice | RESOLVED, that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on healthcare issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers. (New HOD Policy) |
| B | Res. 207 | Michigan | On-Site Physician Requirement for Emergency Departments | RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action) |
| B | Res. 208 | Young Physicians Section | Non-Physician Practitioners Oversight and Training | RESOLVED, that our American Medical Association encourage oversight and regulation of non-physician providers by regulatory bodies comprised of individuals with equivalent and higher levels of training, including state composite medical boards. (New HOD Policy) |
| B | Res. 209 | Medical Student Section | Opposing Pay-to-Stay Incarceration Fees | RESOLVED, that our American Medical Association collaborate with relevant parties, oppose fees charged to incarcerated individuals for room and board, and advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board. (Directive to Take Action) |
| B | Res. 210 | Medical Student Section | Immigration Status in Medicaid and CHIP | RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. (Directive to Take Action) |
| B | Res. 211 | Medical Student Section | Indian Water Rights | RESOLVED, that our American Medical Association will: (1) raise awareness about ongoing water rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in appropriate forums and (2) support improving access to water and adequate sanitation, water treatment, and environmental support and health services on American Indian and Alaska Native trust lands. (New HOD Policy) |
| B | Res. 212 | Medical Student Section | Medical-Legal Partnerships & Legal Aid Services | RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients’ legal needs. (New HOD 2 Policy) |
| B | Res. 213 | Medical Student Section | Health Technology Accessibility for Aging Patients | RESOLVED, that our American Medical Association support the development of a standardized definition of “age-friendliness” in health information technology (HIT) advancements (New HOD Policy)  RESOLVED, that our AMA encourage appropriate parties to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults (New HOD Policy)  RESOLVED, that our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs (Directive to Take Action)  RESOLVED, that our AMA require EHR providers to provide standardized, easily accessible digital storage space for advance care paperwork. (New HOD Policy) |
| B | Res. 214 | Medical Student Section | Humanitarian Efforts to Resettle Refugees | RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States. (New HOD Policy) |
| B | Res. 215 | Medical Student Section | A Public Health-Centered Criminal Justice System | RESOLVED, that our American Medical Association support legislation that reduces the negative health impacts of incarceration by:  a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution,  b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and  c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society (Directive to Take Action)  RESOLVED, that our AMA (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules. (New HOD Policy) |
| B | Res. 216 | Senior Physicians Section | Saving Traditional Medicare | RESOLVED, That our American Medical Association continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion (Directive to Take Action)  RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes that increase revenue streams, reduce waste and inefficiency, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians (Directive to Take Action)  RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action)  RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee a level playing field by using a competitive bidding process to replace the current benchmark system for determining Medicare Advantage bonus payments (Directive to Take Action)  RESOLVED, That our AMA support the “Save Medicare ACT” which proposes renaming Medicare “Advantage” plans as “Alternative Private Health Plans”. (New HOD Policy) |
| B | Res. 217 | International Medical Graduates Section | Addressing Work Requirements for J-1 Visa Waiver Physicians | RESOLVED, That our American Medical Association acknowledge that the requirement of 40 hours of direct patient care could impose a burden on IMG physicians and may hinder opportunities for professional growth (New HOD Policy)  RESOLVED, That our AMA advocate for a revision in the J-1 waiver physician's requirement, proposing a transition to a comprehensive 40-hour work requirement that encompasses both direct clinical responsibilities and other professional activities. (Directive to Take Action) |
| B | Res. 218 | American Academy of Child and Adolescent Psychiatry | Youth Residential Treatment Program Regulation | RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action)  RESOLVED, that our AMA recognize the need for federal licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth. (New HOD Policy) |
| B | Res. 219 | Washington | Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD) | RESOLVED, that our American Medical Association advocate to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder (Directive to Take Action)  RESOLVED, that our AMA advocate that our federal, state, and local governments remove barriers to opioid agonist therapy (including methadone, suboxone or other appropriate treatments) at skilled nursing facilities (Directive to Take Action)  RESOLVED, that our AMA advocate that Medicare and Medicaid provide coverage for substance use and opioid use disorder treatments in skilled nursing facilities. (Directive to Take Action) |
| B | Res. 220 | American College of Legal Medicine | Merit-Based Process for the Selection of all Federal Administrative Law Judges | RESOLVED, that our American Medical Association support the pre-2018, merit-based process for the selection of all federal administrative law judges (ALJs), including the requirements that:  1. All federal ALJ candidates must be licensed and authorized to practice law under the laws of a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the United States Constitution throughout the ALJ selection process,  2. All federal ALJ candidates must have a full seven (7) years of experience as a licensed attorney preparing for, participating in, and/or reviewing formal hearings or trials involving litigation and/or administrative law at the Federal, State, or local level, and  3. All federal ALJ candidates must pass an examination, the purpose of which is to evaluate the competencies/knowledge, skills, and abilities essential to performing the work of an Administrative Law Judge. (New HOD Policy) |
| B | Res. 221 | Oregon | Support for Physicians Pursuing Collective Bargaining and Unionization | RESOLVED, that our American Medical Association convene an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action) |
| B | Res. 222 | Association for Clinical Oncology | Expansion of Remote Digital Laboratory Access Under CLIA | RESOLVED, that our American Medical Association advocate to the Centers for Medicare and Medicaid Services that post-Public Health Emergency enforcement discretion of Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations 42 C.F.R. §§ 493.35(a), 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each laboratory location unless it meets a regulatory exception, be clarified to include all qualified physicians under CLIA, to review digital data, digital results, and digital images at a remote location under the primary location CLIA certificate. (Directive to Take Action) |
| B | Res. 223 | Association for Clinical Oncology | Initial Consultation for Clinical Trials Under Medicare Advantage | RESOLVED, that our American Medical Association amend policy H-460.882, “Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations,” by addition to read as follows:  4. Our AMA advocate that the Centers for Medicare and Medicaid Services allow out-of-network referral of patients with Medicare Advantage for the purpose of consultation for enrollment in a clinical trial, and that these consultations be considered administratively as participation in a clinical trial. (Modify Current HOD Policy) |
| B | Res. 224 | Association for Clinical Oncology | ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers | RESOLVED, that our American Medical Association study enacted state pharmacy benefit management (PBM) legislation and create a model bill that would avoid the Employment Retirement Income Security Act of 1974 (ERISA) preemption. (Directive to Take Action) |
| C | CME 1 | n/a | Leave Policies for Medical Students, Residents, Fellows, and Physicians | The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of the report be filed:   1. That the fifth and fifteenth clauses of AMA Policy [H-405.960](https://policysearch.ama-assn.org/policyfinder/detail/H-405.960?uri=%2FAMADoc%2FHOD.xml-0-3580.xml), “Policies for Parental, Family and Medical Necessity Leave,” be amended by addition and deletion, to read as follows:   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~~.~~, with the understanding that no parent be required to take a minimum leave.  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 (ABMS) 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~~ in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per [ABMS policy](https://www.abms.org/policies/parental-leave/)) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.   1. That AMA Policy [H-405.960](https://policysearch.ama-assn.org/policyfinder/detail/H-405.960?uri=%2FAMADoc%2FHOD.xml-0-3580.xml), “Policies for Parental, Family and Medical Necessity Leave,” be amended by addition to read as follows:   19. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.   1. That the first and fifth clauses of AMA Policy [H-405.947](https://policysearch.ama-assn.org/policyfinder/detail/%22medical%20leave%22?uri=%2FAMADoc%2FHOD.xml-H-405.947.xml), “Compassionate Leave for Medical Students and Physicians,” be amended by addition and deletion with a change in title to read as follows:     Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows ~~and Physicians~~  1. Our AMA urges:  (a) medical schools, and the ~~residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices~~ Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies ~~as part of the physician's standard benefit agreement~~. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree;  (b) residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty;  (c) medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.  5. Our AMA ~~will study~~ supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students ~~and physicians~~, medical trainees, and physician residents and fellows, regardless of gender or gender identity.   1. That the fourth clause of AMA Policy [H-405.960](https://policysearch.ama-assn.org/policyfinder/detail/H-405.960?uri=%2FAMADoc%2FHOD.xml-0-3580.xml), “Policies for Parental, Family and Medical Necessity Leave,” be rescinded, as having been fulfilled by this report.   ~~4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.~~   1. That the second clause of AMA Policy [H-405.947](https://policysearch.ama-assn.org/policyfinder/detail/%22medical%20leave%22?uri=%2FAMADoc%2FHOD.xml-H-405.947.xml), “Compassionate Leave for Medical Students and Physicians,” be rescinded, as having been fulfilled by this report.   ~~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.~~ |
| C | CME 3 | n/a | Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education | The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed:   1. That our AMA encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions. (Directive to Take Action) 2. That our AMA continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions. (New HOD Policy) 3. That our AMA recommend that medical schools use the same interview format for all applicants to the same class to promote equity and fairness. (New HOD Policy) 4. That our AMA recommend that graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness. (New HOD Policy) 5. That AMA Policy D-295.303, “Support Hybrid Interview Techniques for Entry to Graduate Medical Education,” be rescinded, as having been addressed through this report. (Rescind HOD Policy) |
| C | CME 4 | n/a | Recognizing Specialty Certifications for Physicians | The Council on Medical Education therefore recommends that the following resolve be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed.  That our American Medical Association (AMA):   * 1. Encourage continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession 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. (Directive to Take Action)   2. Reaffirm the following policy: * [H-275.926](https://policysearch.ama-assn.org/policyfinder/detail/Medical%2520Specialty%2520Board%2520Certification%2520Standards?uri=%252FAMADoc%252FHOD.xml-0-1904.xml), “Medical Specialty Board Certification Standards” |
| C | CME 5 | n/a | Organizations to Represent the Interests of Resident and Fellow Physicians | The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed:   1. That Our AMA will encourage the formation of peer-led resident/fellow organizations that can advocate for trainees’ interests, as outlined by the AMA’s Residents and Fellows’ Bill of Rights, at sponsoring institutions. (New HOD Policy) 2. That Our AMA will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program. (New HOD Policy) 3. That Our AMA will investigate promoting the current capacity of FREIDATM to post open positions and adding the ability for FREIDATM to facilitate the process of residents and fellows who wish to transfer programs. (Directive to Take Action) 4. That AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by addition, to read as follows (Modify Current HOD Policy):   “12. Our AMA will distribute and promote the Residents and Fellows’ Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.  “13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.” |
| C | Res. 301 | Kelly Caverzagie, MD | Clarification of AMA Policy D-310-948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” | RESOLVED, that our American Medical Association amend Policy D-310.948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” by addition and deletion to read as follows:  Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit for-profit entities and their effect on medical education. (Modify HOD Policy) |
| C | Res. 302 | Medical Student Section | Medical Student Reports of Disability-Related Mistreatment | RESOLVED, that our American Medical Association work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire. (Directive to Take Action) |
| C | Res. 303 | Medical Student Section | Fairness for International Medical Students | RESOLVED, that our American Medical Association encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students (New HOD Policy)  RESOLVED, that our AMA amend policy H-255.968 “Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools” by addition and deletion to read as follows:  Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968  Our AMA:  1. supports the autonomy of medical schools to determine optimal tuition  requirements for international students;  2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;  3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); ~~and~~  4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and  5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. (Modify Current HOD Policy) |
| C | Res. 304 | Medical Student Section | Health Insurance Options for Medical Students | RESOLVED, that our American Medical Association work with relevant parties to urge medical schools to allow students and their families who qualify for and enroll in other health insurance with equal or greater coverage, including Medicaid, the Children’s Health Insurance Program (CHIP), or Affordable Care Act (ACA) Marketplace health insurance plans, to be exempt from otherwise mandatory student health insurance plans (Directive to Take Action)  RESOLVED, that our AMA support the continuation of comprehensive medical insurance benefits for students taking a leave of absence and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. (New HOD Policy) |
| C | Res. 305 | American Association of Public Health Physicians | Addressing Burnout and Physician Shortages for Public Health | RESOLVED, that our American Medical Association vigorously advocate for expanded training opportunities within residency programs, encompassing both preventive medicine residencies and public health physician training, in addition to advocating for increased funding and heightened federal support to address the repercussions of natural disasters (Directive to Take Action)  RESOLVED, that our AMA steadfastly supports the allocation of state and national funds aimed at fortifying the roles of public health physicians, including Public Health and General Preventive Medicine Residency programs in multiple federal Public Health agencies (New HOD Policy)  RESOLVED, that our AMA unequivocally calls for the reinstatement of the CDC Preventive Medicine Residency program or Fellowship, as the CDC is the nation’s premier public health agency. (New HOD Policy) |
| C | Res. 306 | Women Physicians Section | Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies | RESOLVED, that our American Medical Association oppose any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons (New HOD Policy)  RESOLVED, that our AMA encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends. (New HOD Policy) |
| F | BOT 12 | n/a | American Medical Association Meeting Venues and Accessibility | RECOMMENDATION  The Board of Trustees therefore recommends that Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” be amended by addition and deletion as follows in lieu of Resolution 610-A-22, Resolve 2, and Resolution 602-I-22, and the remainder of this report be filed:  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 enacted regulation or 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 and/or primarily sponsored by our AMA 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 will not hold meetings organized by or primarily sponsored by our AMA at venues that have 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. 6. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. 7. 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. 8. 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. 9. Our AMA will utilize security experts to assess the safety risk for our attendees and guests at all venues. (Modify Current HOD Policy) |
| F | BOT 13 | n/a | House of Delegates (HOD) Modernization | RECOMMENDATION  In light of these considerations, your Board of Trustees recommends that:   1. Resolution 622-A-22 not be adopted. 2. Board of Trustees Report 20-A-23 be reaffirmed. |
| F | CLRPD 1 | n/a | Women Physicians Section Five-Year Review | RECOMMENDATION  The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2028 with the next review no later than the 2028 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action) |
| F | HOD Comp Report | n/a | Report of the House of Delegates Committee on the Compensation of the Officers | RECOMMENDATIONS  The Committee on Compensation of the Officers recommends the following recommendation be adopted and the remainder of this report be filed:   1. That the President honorarium be increased by 3% and that the President-Elect, Immediate Past-President, Chair and Chair-Elect honoraria be increased by 2% effective July 1, 2024. These increases result in the following Honoraria:  |  |  | | --- | --- | | **POSITION** | **GOVERNANCE HONORARIUM** | | President | $298,865 | | Immediate Past President | $290,659 | | President-Elect | $290,659 | | Chair | $285,886 | | Chair-Elect | $211,630 | |
| F | Res. 601 | Medical Student Section | Carbon Pricing to Address Climate Change | RESOLVED, that our American Medical Association amend D-135.966 by addition and deletion to read as follows:  Declaring Climate Change a Public Health Crisis D-135.966  Our AMA:  1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.  2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.  3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.  4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.  5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.  6. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.  7. Our AMA will work with the World Medical Association and interested countries’ medical associations on international carbon pricing and other ways to address climate change. (Modify Current HOD Policy) |
| F | Res. 602 | Medical Student Section | Inclusive Language for Immigrants in Relevant Past and Future AMA Policies | RESOLVED, that our American Medical Association utilize the terms “documented," "undocumented," "immigrant,” and/or “noncitizen” in all future policies and publications when broadly addressing the United States immigrant population (New HOD Policy)  RESOLVED, that our AMA revise all relevant and active policies to utilize the term “documented/undocumented immigrant” in place of the terms "legal/illegal immigrant" where such text appears (Modify Current HOD Policy)  RESOLVED, that our AMA revise all relevant and active policies to utilize the term “immigrant/noncitizen” in place of the term "alien" where such text appears. (Modify Current HOD Policy) |
| F | Res. 603 | Texas | Improving the Efficiency of the House of Delegates Resolution Process | RESOLVED, that our American Medical Association House of Delegates instruct its reference committees to issue interim reports of their recommendations (1) based on online testimony and other information received and (2) made available to house members with ample time for delegates to evaluate recommendations and, if desired, prepare comments in advance of live reference committee hearings (Directive to Take Action); and be it further  RESOLVED, that our AMA HOD require resolution authors to submit their initial testimony online and include in detail how the new resolution is not a reaffirmation of existing policy; the authors would have the option of submitting additional testimony during the in-person hearings to respond to any concerns raised in the interim report or in testimony from others. (Directive to Take Action) |
| F | Res. 604 | Resident and Fellow Section | Updating Language Regarding Families and Pregnant Persons | RESOLVED, that our American Medical Association review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures. (Directive to Take Action) |
| F | Res. 605 | Young Physicians Section | Ranked Choice Voting | RESOLVED, that our American Medical Association study ranked-choice voting for all elections within the House of Delegates. (Directive to Take Action) |
| F | Res. 606 | Medical Student Section | Prevention of Healthcare-Related Scams | RESOLVED, that our American Medical Association encourage relevant parties to educate patients and physicians on healthcare-related scams, including how to avoid and report them. (New HOD Policy) |
| F | Res. 607 | The American Academy of Pediatrics | Equity-Focused Person-First Language in AMA Reports and Policies | RESOLVED, That our American Medical Association Board, Council and Task Force reports and recommendations use equity-focused, person-first language consistent with the AMA Advancing Health Equity: A Guide to Language, Narrative and Concepts (Directive to Take Action)    RESOLVED, That our AMA support, as policies are reviewed for sunset, if they are recommended to be maintained in policy, that the review committee recommend amendments as needed to ensure the use of equity-focused, person-first language consistent with the AMA Advancing Health Equity: A Guide to Language, Narrative and Concepts (Directive to Take Action)    RESOLVED, That our AMA encourage sections, state and specialty societies and individual members to use equity-focused, person-first language consistent with the AMA Advancing Health Equity: A Guide to Language, Narrative and Concepts when writing resolutions and include information about and a link to the guide in any educational materials about resolution writing and submission that they develop to share with their groups. (New HOD Policy) |
| F | Res. 608 | Senior Physicians Section | Confronting Ageism in Medicine | RESOLVED, that our American Medical Association develop practical interventions to combat ageism as a part of AMA’s health equity policy (Directive to Take Action)  RESOLVED, that our AMA develop with other interested organizations educational materials, including a podcast, on ageism that can be distributed to medical, nursing and allied health schools, GME programs and CME/CNE providers to advocate for the importance of early interventions in the minimalizations and mistreatment of others (Directive to Take Action)  RESOLVED, that our AMA conduct outreach and collaboration with national senior governmental and private organizations to help educate the public and legislators on the significance of ageism and its subtleties of discrimination, inequities, and exclusions. (Directive To Take Action) |
| F | Speakers’ Report 02 | n/a | Extending Online Forum Trial Through A-24 | RECOMMENDATION:  1. That the trial established by Policy D-600.956 be continued through Annual 2024. |
| J | CMS 1 | n/a | ACO REACH | RECOMMENDATIONS  The Council on Medical Service recommends that the following be adopted in lieu of Resolution 822-I-22, and the remainder of the report be filed:   1. That our American Medical Association reaffirm the following policies:    1. Policy H-160.915, “Accountable Care Organization Principles”    2. Policy H-373.998, “Patient Information and Choice”    3. Policy H-160.892, “Effects of Hospital Integrated System Accountable Care Organizations”    4. Policy D-385.963, “Health Care Reform Physician Payment Models”    5. Policy H-180.944, “Plan for Continued Progress Toward Health Equity”    6. Policy H-160.912, “The Structure and Function of Interprofessional Health Care Teams”    7. Policy D-385.952, “Alternative Payment Models and Vulnerable Populations” (Reaffirm HOD Policy) |
| J | CMS 2 | n/a | Health Insurers and Collection of Patient Cost-Sharing | RECOMMENDATIONS  The Council on Medical Service recommends that the following be adopted in lieu of Resolution 823-I-22, and the remainder of the report be filed:   1. That our American Medical Association (AMA) support requiring health insurers to collect patient cost-sharing and pay physicians their full contracted amount for the health care services provided, unless the physicians opt-out to collect such cost-sharing on their own. (New HOD Policy) 2. That our AMA reaffirm Policy H-165.838, which details the AMA’s ongoing support for affordable and accessible insurance coverage. (Reaffirm HOD Policy) |
| J | CMS 3 | n/a | Strengthening Network Adequacy | RECOMMENDATIONS  The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:   1. That our American Medical Association (AMA) support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy) 2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including but not limited to: 3. Minimum physician-to-enrollee ratios across specialties, including mental health and substance use disorder providers who are accepting new patients; 4. Minimum percentages of non-emergency providers available on nights and weekends; 5. Maximum time and distance standards, including for enrollees who rely on public transportation; 6. Clear standard for network appointment wait times across specialties, for both new patients and continuing care, that are appropriate to a patient’s urgent and non-urgent health care needs; and 7. Sufficient providers to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency. (New HOD Policy) 8. That our AMA encourage the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans and make informed decisions when enrolling in a plan. (New HOD Policy) 9. That our AMA support requiring health plans to report to regulators annually and prominently display network adequacy information so that it is available to enrollees and consumers shopping for plans, including:    1. The breadth of a plan’s provider network, by county and geographic region;    2. Average wait times for primary and behavioral health care appointments as well as common specialty referrals;    3. The number of in-network physicians treating substance use disorder who are actively accepting new patients, and the type of opioid use disorder medications offered;    4. The number of in-network mental health physicians actively accepting new patients; and    5. Instructions for consumers and physicians to easily contact regulators to report complaints about inadequate provider networks and other access problems. (New HOD Policy) 10. That our AMA encourage the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys or interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy, and to identify other access or quality problems. (New HOD Policy) 11. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements. (New HOD Policy) 12. That our AMA support regulation to hold health plans accountable for network inadequacies, including through use of corrective action plans and substantial financial penalties. (New HOD Policy) 13. That our AMA reaffirm Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards including hospital-based physician specialties. (Reaffirm HOD Policy) 14. That our AMA reaffirm Policy H-285.904, which supports principles related to unanticipated out-of-network care and advocates that state regulators should enforce network adequacy standards through active regulation of health plans. (Reaffirm HOD Policy) 15. That our AMA reaffirm Policy H-285.902, which urges the Centers for Medicare & Medicaid Services to take several steps to ensure network adequacy, enhance provider directory accuracy, measure network stability, and effectively communicate provider network information to patients. (Reaffirm HOD Policy) 16. That our AMA reaffirm Policy H-285.911, which advocates that health insurance provider networks be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (Reaffirm HOD Policy) |
| J | CMS 5 | n/a | Medicaid Unwinding Update | RECOMMENDATIONS  The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:   1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to read:   4. Our AMA encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons, including automating renewal processes and following up with enrollees who have not responded to a renewal request, using multiple modalities, before terminating coverage.  5. Our AMA encourages states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan that does not include their treating physicians and other providers in network, and to recognize prior authorizations completed under the prior Medicaid/CHIP plan.  6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state’s portal or by other readily accessible means. (Modify HOD Policy)   1. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, Children’s Health Insurance Program, and exchange plans and supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy) |
| J | CMS 6 | n/a | Rural Hospital Payment Models | RECOMMENDATIONS  The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:   1. That our American Medical Association (AMA) support and encourage efforts to develop and implement proposals for improving payment models to rural hospitals. (New HOD Policy) 2. That our AMA reaffirm Policy H-465.978, which recognizes the payment bias toward rural hospitals as a factor in rural health disparities and encourages solutions to help solve this bias. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy D-465.998, which advocates for improvements to the payment and health care service delivery in rural hospitals. (Reaffirm HOD Policy) 4. That our AMA rescind Policy D-465.996 as having been accomplished with this report. (Rescind HOD Policy) |
| J | CMS 7 | n/a | Sustainable Payment for Community Practices | RECOMMENDATIONS  The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:   1. That our American Medical Association (AMA) amend Policy H-290.976[2] by addition and deletion, and modify the title by deletion, as follows:   Enhanced ~~SCHIP~~ Enrollment, Outreach, and ~~Reimbursement~~ Payment H-290.976  1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.  2. Our AMA affirms its commitment to advocating for reasonable SCHIP, ~~and~~ Medicaid, and private insurance payment ~~reimbursement~~ for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)   1. That our AMA amend Policy H-385.921 by addition and deletion, and modify the title by deletion, as follows:   Health Care Access ~~for Medicaid Patients~~ H-385.921  It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, ~~and~~ any other publicly funded insurance plan, and private insurance must be at minimum 100 percent of the RBRVS Medicare allowable. (Modify Current HOD Policy)   1. That our AMA reaffirm Policy D-400.990, which seeks legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)   6. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy) |
| J | Res. 801 | Medical Student Section | Improving Pharmaceutical Access and Affordability | RESOLVED, that our American Medical Association supports lowering out-of-pocket maximums in insurance plans including but not limited to ERISA plans, other forms of employer-sponsored insurance, plans offered on the ACA marketplace, TRICARE, and any other public or private payers (New HOD Policy)  RESOLVED, that our AMA oppose Direct Member Reimbursement plans, where patients pay the full retail costs of a prescription drug that they may then be reimbursed for, due to their potential to expose patients to significant out-of-pocket costs. (New HOD Policy) |
| J | Res. 802 | Medical Student Section | Improving Nonprofit Hospital Charity Care Policies | RESOLVED, that our American Medical Association advocate for legislation and regulations that require nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing (Directive to Take Action)  RESOLVED, that our AMA support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility (New HOD Policy)  RESOLVED, that our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities. (New HOD Policy) |
| J | Res. 803 | Medical Student Section | Improving Medicaid and CHIP Access and Affordability | RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children’s Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy)  RESOLVED, that our AMA amend policy H-290.982 “Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured” by deletion as follows;  Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982  AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;  (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.  (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;  (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;  (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;  (6) urges states to administer their Medicaid and SCHIP programs through a single state agency;  (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;  (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;  (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;  (~~10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;~~ (Modify Current HOD Policy)  RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums to Medicaid beneficiaries. (New HOD Policy) |
| J | Res. 804 | AMDA – The Society for Post-Acute and Long-Term Care Medicine | Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity | RESOLVED, that our American Medical Association advocate for a change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow clinicians with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity. (Directive to Take Action) |
| J | Res. 805 | Michigan | Medication Reconciliation Education | RESOLVED, that our American Medical Association work with Centers for Medicare and Medicaid Services and other appropriate organizations to study current medication-reconciliation practices across transitions of care with dissimilar electronic health records to evaluate the impact on patient safety and quality of care, and to determine the potential need for additional training to reduce medical errors and ensure patient safety and quality of care (Directive to Take Action)  RESOLVED, that our American Medical Association work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action) |
| J | Res. 806 | Michigan | Evidence-Based Anti-Obesity Medication as a Covered Benefit | RESOLVED, that our American Medical Association amend Policy H-150.953, “Obesity as a Major Public Health Problem,” by addition as follows:  9. Urge national payors to ensure coverage parity for FDA-approved anti-obesity medications without exclusions or additional carve-outs. (Modify Current HOD Policy) |
| J | Res. 807 | Young Physicians Section | Any Willing Provider | RESOLVED, that our American Medical Association shall develop and advocate for model "Any Willing Provider" legislation nationwide, enabling all physicians to build successful practices and deliver quality patient care (Directive to Take Action)  RESOLVED, that our AMA shall lobby for federal regulations or legislation mandating insurers to implement "Any Willing Provider" policies as a prerequisite for participating in federally-supported programs (Directive to Take Action)  RESOLVED, that our AMA will work with state and national organizations, including insurance companies, to promote and support the adoption of "Any Willing Provider" laws, and will monitor the implementation of these laws to ensure that they are having a positive impact on access to quality healthcare. (Directive to Take Action) |
| J | Res. 808 | Young Physicians Section | Prosthodontic Coverage after Oncologic Reconstruction | RESOLVED, that our American Medical Association with appropriate stakeholders to advocate: (a) that prosthodontic reconstruction (including dental implants) after orofacial reconstruction secondary to oncologic resection be covered by all insurers, (b) that such coverage, shall include treatment which, in the opinion of the treating physician is medically necessary to optimize the patient’s appearance and function to their original form as much as possible, and (c) that such insurability be portable, i.e. not denied as a pre-existing condition if the patients insurance coverage changes before treatment has been initiated or completed. (Directive to Take Action) |
| J | Res. 809 | New York | Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion | RESOLVED, that our American Medical Association advocate that health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US should implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (Directive to Take Action)  RESOLVED, that our AMA support national legislation that calls on health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US to implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (New HOD Policy)  RESOLVED, that our AMA advocate for fair treatment of outsourced employees in vastly different time zones by health plans. (Directive to Take Action) |
| J | Res. 810 | Medical Student Section | Racial Misclassification | RESOLVED, that our American Medical Association amend H-85.953, “Improving Death Certification Accuracy and Completion,” by addition as follows:  Improving Death Certification Accuracy and Completion H-85.953  1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.  2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.  3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.  4. Our AMA further supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification. (Modify Current HOD Policy) |
| J | Res. 811 | Medical Student Section | Expanding the Use of Medical Interpreters | RESOLVED, that our American Medical Association amend H-160.924, “Use of Language Interpreters in the Context of the Patient-Physician Relationship,” by addition as follows:  Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924  1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; d) patients have expanded access to documentation and communications available in their preferred language, including appointment reminder calls/messages, post-appointment summaries, and electronic medical records, through access to trained interpreter and translator services; and (~~d~~e) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.  2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.  3. Our AMA encourage hospital systems, clinics, residency programs, and medical schools to promote and incentivize opportunities for physicians, staff, and trainees to receive medical interpreter training and certification. (Modify Current HOD Policy) |
| J | Res. 812 | Medical Student Section | Indian Health Service Improvements | RESOLVED, that our American Medical Association advocate to permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) (Directive to Take Action)  RESOLVED, that our AMA encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs (New HOD Policy)  RESOLVED, that our AMA advocate for greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population (Directive to Take Action)  RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients (Directive to Take Action)  RESOLVED, that our AMA support permanent reauthorization of the Special Diabetes Program for Indians (New HOD Policy)  RESOLVED, that our AMA support biannual inflationary increases for public health and health profession grants sponsored by IHS. (New HOD Policy) |
| J | Res. 813 | Medical Student Section | Strengthening Efforts Against Horizontal & Vertical Consolidation | RESOLVED, that our American Medical Association advocate to adequately resource competition policy authorities such as the Federal Trade Commission (FTC) and Department of Justice Antitrust Division to perform oversight of healthcare markets (Directive to Take Action)  RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals (New HOD Policy)  RESOLVED, that our AMA support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny (New HOD Policy)  RESOLVED, that our AMA support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, including but not limited to a) simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated healthcare markets. (New HOD Policy) |
| J | Res. 814 | Senior Physicians Section | Providing Parity for Medicare Facility Fees | RESOLVED, That our American Medical Association promote awareness that the ‘site of service’ payment differential does not reflect quality of care (Directive to Take Action)  RESOLVED, That our AMA seek legislative action or relief for independent physician practices, including rural and underserved practices, to be paid equally for office-based procedures whether or not they practice in offices, facilities, or hospitals (Directive to Take Action)  RESOLVED, That our AMA amend policy D-330.902, The Site-of-Service Differential, by addition to read as follows:  Our AMA will produce a graphic report yearly 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. (Modify Current HOD Policy) |
| J | Res. 815 | Senior Physicians Section | Long-Term Care and Support Services for Seniors | RESOLVED, That our American Medical Association advocate that private payors offer an affordable insurance product[s] to address long-term care needs (Directive to Take Action)  RESOLVED, That our AMA with other interested organizations, including the insurance industry, explore ways to ensure the viability of long-term care insurance by a mix of mandates and/or incentives that can be advocated for (Directive to Take Action)  RESOLVED, That our AMA advocate for equity in the financing of long-term care in order to assure affordable care of long-term care for all Americans (Directive To Take Action)  RESOLVED, That our AMA reaffirm Policy H-25.991, to continue to advocate for fiscal support for “aging in place” by promoting state and federal policy to expand home and community-based services (Reaffirm HOD Policy)  RESOLVED, That our AMA promote research regarding evidence-based interventions to assure the quality of long-term care for seniors both in the home and institutional settings. (Directive to Take Action) |
| J | Res. 816 | GLMA: Health Professionals Advancing LGBTQ+ Equality | Reducing Barriers to Gender-Affirming Care through Improved Payment and Reimbursement | RESOLVED, that our American Medical Association appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care. (Directive to Take Action) |
| J | Res. 817 | The American Academy of Pediatrics | Expanding AMA Payment Reform Work and Advocacy to Medicaid and other non-Medicare payment modules for Pediatric Healthcare and Specialty Populations | RESOLVED, That our American Medical Association examine and report back on demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena (Directive to Take Action)  RESOLVED, That our AMA extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts (Directive to Take Action)    RESOLVED, That our AMA support and work with medical specialty societies who are developing alternative payment models for pediatric healthcare (New HOD Policy)    RESOLVED, That our AMA consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care. (New HOD Policy) |
| J | Res. 818 | New England | Amendment to AMA Policy on Healthcare System Reform Proposals | RESOLVED, that our American Medical Association remove opposition to single-payer healthcare delivery systems from its policy, and instead evaluate all healthcare system reform proposals based on our stated principles as in AMA policy (Directive to Take Action)  RESOLVED, that our AMA support a national unified financing healthcare system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients. (New HOD Policy) |
| J | Res. 819 | New York | Amend Virtual Credit Card Policy | RESOLVED, that our American Medical Association make no further statements regarding the “legality” of Virtual Credit Cards (VCCs) (New HOD Policy)  RESOLVED, that our AMA advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments (Directive to Take Action)    RESOLVED, that our AMA advocate on behalf of physicians and plainly state that in no circumstance is it advisable or beneficial for medical practices to get paid by VCCs. (Directive to Take Action) |
| J | Res. 820 | Oregon | Affordability and Accessibility of Treatment of Overweight and Obesity | RESOLVED, that our American Medical Association join in efforts to convince Congress to address the affordability and accessibility of prevention and evidence-based treatment of obesity across the United States as well as, urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to: 1. Revise their policies to ensure that prevention and evidence-based treatment of obesity is covered for patients who meet the appropriate medical criteria; and 2. Ensure that insurance policies in their states do not discriminate against potential evidence-based treatment of obese patients based on age, gender, race, ethnicity, socioeconomic status. (Directive to Take Action) |
| K | BOT 02 | n/a | Opposing the Use of Vulnerable Incarcerated People in Response to Public  Health Emergencies | The Board of Trustees recommends that the following be adopted in lieu of Resolution 901-I-22, and the remainder of this report be filed.   1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices. 2. Our AMA supports:    1. Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.    2. Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.    3. Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person’s incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.    4. The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties. 3. Our AMA encourages:    1. Congress and state legislatures to clarify the meaning of “employee” to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.    2. Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.    3. Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.    4. The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities. 4. Our AMA encourages: 5. Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers. 6. That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights. 7. That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses. 8. Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion. 9. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals’ prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society. 10. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors. |
| K | BOT 05 | n/a | AMA Public Health Strategy: The Mental Health Crisis | RECOMMENDATIONS  The Board of Trustees recommends that the second directive of BOT Report 17 be rescinded as having been accomplished by this report. (Rescind HOD Policy) |
| K | BOT 14 | n/a | Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home | RECOMMENDATION  The Board of Trustees recommends that Alternate Resolution 923 be adopted in lieu of Resolution 923 and that the remainder of the report be filed:  RESOLVED, That our AMA encourage health departments and local governments to partner with police departments, fire departments, and other public safety entities and organizations to make firearm safe storage devices accessible (available at low or no cost) in communities in collaboration with schools, hospitals, clinics, physician offices, and through other interested stakeholders. (New HOD Policy) |
| K | CSAPH 1 | n/a | Drug Shortages: 2023 Update | Recommendations  The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution I-22-935, and that the remainder of the report be filed:   1. That Policy H-100.956, “National Drug Shortages,” be amended by addition to read as follows: 2. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. 3. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion. 4. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage. 5. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant. 6. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages. 7. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces. 8. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons. 9. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history. 10. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. 11. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. 12. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages. 13. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages. 14. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages. 15. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing. 16. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling. 17. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes. 18. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities. 19. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan. 20. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.   20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.  21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.  22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.  23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary. (Amend HOD Policy)   1. That the following policy be adopted:   Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages    Our AMA:  (1) supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.  (2) encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives. (New HOD Policy) |
| K | CSAPH 2 | n/a | Precision Medicine and Health Equity | Recommendations  The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:  1. That our AMA:   1. recognizes past and ongoing practices in the field of genetics, including eugenics, have resulted in harm and decreased the quality of care available to minoritized and marginalized groups, and undermined their trust in the available care. Our AMA strongly supports efforts to counter the impact of these practices. 2. supports efforts to increase the diversity of genetics research participants and for research participants and impacted communities to be appropriately compensated. 3. strongly opposes the use of race, ethnicity, genetic ancestry, sexual orientation, or gender identity as the basis for genetic testing recommendations, or the insurance coverage of genetic tests. 4. supports policies which restrict access to genetic databases, including newborn screening samples or carrier screening results, by law enforcement without a warrant. States should clearly outline procedures for law enforcement to obtain access to genetic databases when there are compelling public safety concerns, consistent with AMA patient privacy policy. 5. supports an affirmative consent or “opt-in” approach to genetics research including samples stored within large databases and encourages those in stewardship of genetic data to regularly reaffirm consent when appropriate. 6. recognizes that an individual’s decision to participate in genetics research can impact others with shared genetic backgrounds and encourages researchers and funding agencies to collaborate with impacted community members to develop guidelines for obtaining and maintaining group consent, in addition to individual informed consent. Our AMA supports widespread use of a robust consent process which informs individuals about what measures are being taken to keep their information private, the difficulties in keeping genetic information fully anonymous and private, and the potential harms and benefits that may come from sharing their data. 7. strongly opposes research seeking to find genetic causes for protected traits, including gender identity, sexual orientation, and differences in ability, unless specifically requested by, or in direct collaboration with, the impacted community. (New HOD Policy)   2. That current AMA policies H-315.983, “Patient Privacy and Confidentiality,” H-65.953 “Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice,” and D-350.981 “Racial Essentialism in Medicine” be reaffirmed. (Reaffirm HOD Policy) |
| K | CSAPH 3 | n/a | HPV-Associated Cancer Prevention | RECOMMENDATIONS  The Council on Science and Public Health recommends that the following be adopted, and the  remainder of the report be filed.  1. That our AMA amend policy H-440.872, “HPV-Associated Cancer Prevention” by addition and deletion to read as follows:  HPV-Associated Cancer Prevention, H-440.872  1. Our AMA (a) strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients’ parents when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.  2. Our AMA will work with interested parties to 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 cancer screening in the general public.  3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.  4. Our AMA:  (a) encourages the integration of HPV vaccination and ~~routine cervical~~ appropriate HPV-related cancer screening into all appropriate health care settings and visits,  (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups ~~that benefit most from preventive measures~~, including but not limited to low-income and pre-sexually active populations,  (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.  5. Our AMA encourages ~~will encourage~~ all efforts by interested parties ~~appropriate stakeholders~~ ~~to investigate means~~ to increase HPV vaccine availability, and HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings ~~including school settings~~ such as local health departments, schools, and organized childcare centers.  ~~6. Our AMA will study requiring HPV vaccination for school attendance.~~  6~~7~~. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.  8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; and (b) the impact of broad opt-out provisions on HPV vaccine uptake. (Amend Current HOD Policy)  2.That our AMA reaffirm Policy H-440.970, “Nonmedical Exemptions from Immunizations.”  (Reaffirm HOD Policy) |
| K | CSAPH 4 | n/a | Supporting and Funding Sobering Centers | RECOMMENDATIONS  The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 913-I-22, and the remainder of the report be filed:  1. That our AMA will:   * + 1. Monitor the scientific evidence and encourage further research of sobering centers and similar entities for best practices including:   (1) Health outcomes from sobering center utilization;  (2) Partnerships with medical personnel and health care entities for policies, protocols and procedures that improve patient outcomes, such as transitions of care and safety measures; (3) The appropriate level of medical collaboration, evaluation, support, and training of staff in sobering centers;  (4) Health economic analyses for sobering care models in comparison to existing health care, criminal-legal, and community-based systems; and  (5) Best practices for sobering centers based on location (e.g., urban, suburban, and rural).   * + 1. Support state and local efforts to decriminalize public intoxication.     2. Support federal and state-based regulation of sobering centers.     3. Encourage and support local, state, and federal efforts (e.g., funding, policy, regulations) to establish safe havens for sobering care, as an alternative to criminalization, with harm reduction services and linkage to evidence-based treatment in place of EDs or jails/prisons for medically uncomplicated intoxicated persons. (New HOD Policy)      1. That our AMA reaffirm the following policies HOD policies:  * H-345.995, “Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill,” * H-95.912, “Involuntary Civic Commitment for Substance Use Disorder,” * H-95.931, “AMA Support for Justice Reinvestment Initiatives,” * H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” and * D-430.993, “Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections.” (Reaffirm HOD Policies) |
| K | CSAPH 5 | n/a | Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room | RECOMMENDATIONS  The Council on Science and Public Health recommends that the following recommendations be adopted and the remainder of this report be filed:  1. That Resolution 936-I-22, which asks for our AMA to 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 be adopted. (New HOD Policy)  2. That Policy H-480.959, “Reprocessing of Single-Use Medical Devices,” be reaffirmed. (Reaffirm Existing Policy)  3.That our AMA work with interested parties to establish best practices for safe reuse of equipment and improved surgical kits used in the operating room, and to disseminate best practices for reducing waste in the operating room as well as guides for implementing more sustainable purchasing processes in health care. (New HOD Policy) |
| K | CSAPH 6 | n/a | Marketing Guardrails for the "Over-Medicalization" of Cannabis Use | RECOMMENDATIONS  The Council on Science and Public Health recommends that the following recommendations be adopted and the remainder of the report be filed.  A. Our AMA supports and encourages:   1. research on the effects of cannabis marketing to identify best practices in protecting vulnerable populations, as well as the benefits of public health campaigns such as preventing impaired driving or dangerous use. 2. state regulatory bodies to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities. 3. social media platforms to set a threshold age of 21 years for exposure to cannabis advertising and marketing and improve age verification practices on social media platforms. 4. regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis marketing. (New HOD Policy)   B. That our AMA reaffirm policies:   * H-95.952, “Cannabis and Cannabinoid Research,” that calls for further funding for adequate and well-controlled studies of cannabis and cannabis derived products and support of the rescheduling of cannabis, and * H-95.923, “Taxes on Cannabis Products,” that notes our AMA’s encouragement of states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance [use] prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts. (Reaffirm HOD Policy) |
| K | CSAPH 7 | n/a | Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities | RECOMMENDATIONS  The Council on Science and Public Health recommends that the following recommendations be adopted, and the remainder of the report be filed.   1. That existing AMA policies on preventing violence against health care professionals be reaffirmed:   D-515.983, “Preventing Violent Acts Against Health Care Providers,” H-515.966, “Violence and Abuse Prevention in the Health Care Workplace,” H-515.957, “Preventing Violent Acts Against Health Care Providers,” H-215.977, “Guns in Hospitals,” and H-515.950, “Protecting Physicians and Other Healthcare Workers in Society.” (Reaffirm Existing Policy)   1. That our AMA encourages: (1) additional funding and research to evaluate effective interventions to prevent workplace violence against physicians and other health care professionals, including the effectiveness of magnetometers and other weapons interdiction systems in health care facilities; (2) health care facilities that have implemented magnetometers and other weapons interdiction systems to evaluate the impact on workplace violence and share best practices, including equity considerations; (3) the dissemination and awareness of guidance by OSHA and other organizations on the prevention of violence in health care facilities, including hospitals, ambulatory centers, and other clinical settings. (New HOD Policy) |
| K | Res. 901 | Arizona | Silicosis from Work with Engineered Stone | RESOLVED, That our American Medical Association should encourage physicians, including occupational health physicians, pulmonologists, radiologists, pathologists, and other health-care professionals, to report all diagnosed or suspected cases of silicosis in accordance with National Institute for Occupational Safety and Health (NIOSH) guidance (New HOD Policy)  RESOLVED, That our AMA should advocate for the establishment of preventive measures to reduce exposure of workers to silica levels above the OSHA permissible exposure level (PEL) for respirable crystalline silica, which is a time-weighted average (TWA) of 50 micrograms per cubic meter (µg/m3) of air (Directive to Take Action)  RESOLVED, That our AMA should advocate for the establishment of a registry of cases of silicosis to be maintained for workers diagnosed with silicosis resulting from engineered stonework or from other causes, either by state Departments of Public Health or their Division of Occupational Safety and Health (Directive to Take Action)  RESOLVED, That our AMA should advocate for the establishment of state funds to compensate workers who have been diagnosed with silicosis resulting from their work with silica, to recognize the progression and the need for increasing levels of compensation over time (Directive to Take Action)  RESOLVED, That our AMA recommends that State Medical Associations should take action with respect to the prevention of silicosis and to the recognition and compensation of affected workers in their states. (New HOD Policy) |
| K | Res. 902 | Integrated Physician Practice Section | Post Market Research Trials | RESOLVED, that our American Medical Association advocate that the Food and Drug Administration use its authority to require and enforce timely completion of post-marketing trials or studies whenever sponsors rely on surrogate endpoints to support approval (Directive to Take Action)  RESOLVED, that our AMA advocate that the Food and Drug Administration use its authority to require that pharmaceuticals that received approval using surrogate endpoints demonstrate direct clinical benefit in post-market trials as a condition of continued approval (Directive to Take Action)  RESOLVED, that our AMA advocate that the Food and Drug Administration require drug manufacturers to make the findings of their post-market trials publicly available. (Directive to Take Action) |
| K | Res. 903 | Medical Student Section | Supporting Emergency Anti-Seizure Interventions | RESOLVED, that our American Medical Association support efforts in the recognition of status epilepticus and bystander intervention trainings (New HOD Policy)  RESOLVED, that our AMA encourage physicians to educate patients and families affected by epilepsy on status epilepticus and work with patients and families to develop an individualized action plan for possible status epilepticus, which may include distribution of home pharmacotherapy for status epilepticus, in accordance with the physician's best clinical judgment. (New HOD Policy) |
| K | Res. 904 | Medical Student Section | Universal Return-to-Play Protocols | RESOLVED, that our American Medical Association encourage interested parties to: (a) establish a standard, universal protocol for return-to-play recovery for collegiate and professional athletes; (b) promote additional evidence-based studies on the effectiveness of a universal protocol for evaluation and post-injury management course at the collegiate and professional level; (c) support national and state efforts to minimize the consequences of inadequate recovery windows for collegiate and professional athletes. (New HOD Policy) |
| K | Res. 905 | Medical Student Section | Support for Research on the Relationship Between Estrogen and Migraine | RESOLVED, that our American Medical Association support further research regarding the role of estrogen as a risk factor for stroke and cardiovascular events at the dosages and routes found in, inclusive of but not limited to combined oral contraceptive pills, vaginal rings, transdermal patches, hormone replacement therapy, and gender affirming hormone therapy in individuals with migraine and migraine with aura (New HOD Policy)  RESOLVED, that our AMA work with relevant stakeholders to advocate for increased resources to allow for appropriate education and assessment, when indicated, of migraine and migraine with aura consistent with current diagnostic guidelines in medical practice sites inclusive of but not limited to primary care, obstetrics and gynecology, endocrinology, neurology, and cardiology clinics. (Directive to Take Action) |
| K | Res. 906 | Medical Student Section | Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices | RESOLVED, that our American Medical Association amend policy H-485.994, “Television Broadcast of Sexual Encounters and Public Health Awareness” by addition and deletion, to read as follows:  Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms, H-485.994  The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex. (Modify Current HOD Policy) |
| K | Res. 907 | Medical Student Section | Occupational Screenings for Lung Disease | RESOLVED, that our American Medical Association amend Policy H-365.988, “Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies” by addition and deletion as follows:  Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies, H-365.988  Our AMA ~~supports~~: (1) supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) supports taking a leadership role in assisting state medical societies in implementation of such programs; ~~and~~ (3) supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognizes barriers to accessibility and utilization of such programs; (5) recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase accessibility of these screenings in marginalized communities; and (6) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings. (Modify Current HOD Policy) |
| K | Res. 908 | Michigan | Sexuality and Reproductive Health Education | RESOLVED, that our American Medical Association reaffirm AMA Policy H-170.968, “Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,” and continue to advocate for the adoption of developmentally appropriate, culturally competent, comprehensive sexuality and reproductive health education and reproductive rights curriculum. (Reaffirm HOD Policy) |
| K | Res. 909 | Medical Student Section | High Risk HPV Subtypes in Minoritized Populations | RESOLVED, that our American Medical Association amend H-440.872, “HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide,” by addition as follows:  HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide H-440.872  1. Our AMA (a) urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related 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 cancer screening in the general public.  3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits; (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations; and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.  4. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.  5. Our AMA will study requiring HPV vaccination for school attendance.  6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.  7. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.  8. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines. (Modify Current HOD Policy) |
| K | Res. 910 | Medical Student Section | Sickle Cell Disease Workforce | RESOLVED, that our American Medical Association amend H-350.973, “Sickle Cell Disease,” by addition to read as follows:  Sickle Cell Disease H-350.973  Our AMA:  (1) recognizes sickle cell disease (SCD) as a chronic illness;  (2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;  (3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;  (4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;  (5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;  (6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;  (7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; ~~and~~  (8) encourages the development of model school policy for best in-school care for children with sickle cell disease;  (9) supports expanding the health care and research workforce taking care of patients with sickle cell disease; and  (10) collaborates with relevant parties to advocate for improving access to comprehensive, quality, and preventive care for individuals with sickle cell disease, to address crucial care gaps that patients with sickle cell disease face and improve both the quality of care and life for patients affected by sickle cell disease. (Modify Current HOD Policy) |
| K | Res. 911 | Medical Student Section | Support for Research on the Nutritional and Other Impacts of Plant-Based Meat | RESOLVED, that our American Medical Association work with appropriate parties to support plant-based meat research funding. (Directive to Take Action) |
| K | Res. 912 | Medical Student Section | Fragrance Regulation | RESOLVED, that our American Medical Association recognize fragrance sensitivity as a disability where the presence of fragranced products can limit accessibility of healthcare settings (New HOD Policy)  RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind (New HOD Policy)  RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care (Directive to Take Action)  RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization in the use of a “fragrance free” designation (Directive to Take Action)  RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one’s body. (New HOD Policy) |
| K | Res. 913 | Medical Student Section | Public Health Impacts of Industrialized Farms | RESOLVED, that our American Medical Association recognize Concentrated Animal Feeding Operations (CAFOs) as a public health hazard (New HOD Policy)  RESOLVED, that our AMA encourage the Environmental Protection Agency and appropriate parties to remove the regulatory exemptions for CAFOs under the Emergency Planning and Community Right-to-Know Act and the Comprehensive Environmental Response, Compensation, and Liability Act and tighten restrictions on pollution from CAFOs. (New HOD Policy) |
| K | Res. 914 | The American Academy of Pediatrics | Adverse Childhood Experiences | RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC) and other relevant interested parties to advocate for the addition of witnessing violence, experiencing discrimination, living in an unsafe neighborhood, experiencing bullying, placement in foster care, migration-related trauma, and living in poverty, and any additional categories as needed and justified by scientific evidence to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them (Directive to Take Action)  RESOLVED, That our AMA work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions (Directive to Take Action)  RESOLVED, that our AMA support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child. (New HOD Policy) |
| K | Res. 915 | American Academy of Child and Adolescent Psychiatry | Social Media Impact on Youth Mental Health | RESOLVED, that our American Medical Association work with relevant parties to develop guidelines for age-appropriate content and access and to develop age-appropriate digital literacy training to precede social media engagement among children and adolescents (Directive to Take Action)  RESOLVED, that our AMA amend policy D-478.965 by insertion as follows:  (4) advocates for and support media and social networking services addressing and developing safeguards for users, including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and to develop age-appropriate digital literacy training (Modify Current HOD Policy)  RESOLVED, that our AMA advocate that the federal government requires social media companies to share relevant data for further independent research on social media’s effect on youth mental health and fund future federal research on the potential benefits and harms of social media use on youth mental health. (Directive to Take Action) |
| K | Res. 916 | Washington | Elimination of Buprenorphine Dose Limits | RESOLVED, that our American Medical Association support flexibility in dosing of buprenorphine by elimination of non-evidence-based dose limits imposed by clinics, health systems, pharmacies and insurance carriers (New HOD Policy)  RESOLVED, that our AMA advocate for the elimination of non-evidence-based buprenorphine dose limits imposed by the United States Food and Drug Administration, clinics, health systems, pharmacies, and insurance carriers. (Directive to Take Action) |
| K | Res. 917 | New England | Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals | RESOLVED, that our American Medical Association improve physician and public education around the adverse health effects of PFAS and potential mitigation and prevention efforts. (Directive to Take Action) |
| K | Res. 918 | New England | Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals | RESOLVED, that our American Medical Association condemns the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals and outpatient health care settings (New HOD Policy)  RESOLVED, that our AMA advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate (Directive to Take Action)  RESOLVED, that our AMA advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians. (Directive to Take Action) |
| K | Res. 919 | Indiana | Lithium Battery Safety | RESOLVED, that our American Medical Association seek legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries. (Directive to Take Action) |
| K | Res. 920 | Indiana | Antipsychotic Medication Use for Hospice Patients | RESOLVED, that our American Medical Association seek legislation or regulatory changes that exempt hospice patients from limitations on the use of antipsychotic medications for behavioral changes. (Directive to Take Action) |
| K | Res. 921 | Women Physicians Section | Addressing Disparities and Lack of Research for Endometriosis | RESOLVED, that our American Medical Association collaborate with stakeholders to recognize endometriosis as an area for health disparities research that continues to remain critically underfunded, resulting in a lack of evidence-based guidelines for diagnosis and treatment of this condition amongst people of color (Directive to Take Action)  RESOLVED, that our AMA collaborate with stakeholders to promote awareness of the negative effects of a delayed diagnosis of endometriosis and the healthcare burden this places on patients, including health disparities among patients from communities of color who have been historically marginalized (Directive to Take Action)  RESOLVED, that our AMA advocate for increased endometriosis research addressing health disparities in the diagnosis, evaluation, and management of endometriosis (Directive to Take Action)  RESOLVED, that our AMA advocate for increased funding allocation to endometriosis-related research for patients of color, especially from federal organizations such as the National Institutes of Health. (Directive to Take Action) |
| K | Res. 922 | American Association of Neurological Surgeons | Prescription Drug Shortages and Pharmacy Inventories | RESOLVED, that our American Medical Association work with the pharmacy industry to develop and implement a mechanism to transfer prescriptions without requiring a new prescription (Directive to Take Action)  RESOLVED, that our AMA advocate for legislation and/or regulations permitting pharmacies to transfer prescriptions to other pharmacies when prescription medications are unavailable at the original pharmacy or the patient requests the prescription be transferred. (Directive to Take Action) |

† Only the first organization is listed for those resolutions sponsored by multiple entities