MEMORIAL RESOLUTIONS ADOPTED UNANIMOUSLY

Lawrence "Larry" Monahan, MD
Introduced by Organized Medical Staff Section

Whereas, After a long and distinguished career in internal medicine, Lawrence "Larry" Monahan, MD, passed away on November 23, 2020, at age 79; and

Whereas, Dr. Monahan was highly regarded by his colleagues, patients, friends, and family as a careful, kind, and caring physician, an excellent teacher, and a role model for medical students, interns, and residents; and

Whereas, After having received his B.A. Degree from Kansas State University and his M.D. from the University of Kansas School of Medicine, Dr. Monahan came to adopt the state of Virginia as his home following his internship in Roanoke and eventually establishing his practice in Roanoke and Salem; and

Whereas, Dr. Monahan was an active member of the United States Navy Reserve for 30 years, serving on active duty in Vietnam and stateside from 1970-1972, eventually achieving the rank of Captain in the Medical Core and returning to active duty during Operation Desert Shield/Storm from 1990-1991 before retiring in 1999; and

Whereas, Dr. Monahan was dedicated to his students and the study of medicine in his positions of Clinical Professor of Internal Medicine at both the University of Virginia School of Medicine in Roanoke and the Virginia College of Osteopathic Medicine in Blacksburg; and

Whereas, Dr. Monahan's commitment to the practice of medicine was reflected in his position as a Fellow of the American College of Physicians, his numerous publications in state and national medical journals, and receiving the American Medical Association's Continuing Medical Education Award every year of his practice; and

Whereas, Dr. Monahan's engagement in organized medicine began with his local community, serving as Chairman of the Board of Directors of the Roanoke Valley Academy of Medicine and President of the Virginia Society of Internal Medicine; and

Whereas, That engagement continued at the state medical society level, with Dr. Monahan serving as a member of the Medical Society of Virginia (MSV) for 46 years, during which time he was a Delegate to the annual meeting of the House of Delegates of the MSV for 43 years, actively participated on the Medical Society of Virginia Political Action Committee and Medical Society of Virginia Foundation boards, and distinguished himself in prominent leadership roles including Speaker of the House, First Vice President, and President of the MSV; and

Whereas, Dr. Monahan was a lifetime member of our AMA and a valued AMA leader, serving as a Delegate to the AMA House of Delegates from the state of Virginia for more than 30 years and attending each Annual and Interim meeting during that time; and

Whereas, Dr. Monahan was an active member of the Organized Medical Staff Section, representing his hospital for more than 30 years, serving as State Chair, and most recently serving as Member at-Large on the OMSS Governing Council; and
Whereas, Dr. Monahan was a life-long devotee to music, both in study and in performance as an organist, as well as an accomplished competitive ballroom dancer and outdoor enthusiast; and

Whereas, Dr. Monahan was a loving and devoted husband to his wife, Davida, father to daughter Ashley and son Evan, and grandfather to Payton, Alex, and Aiden, and a true friend and boon companion to all who met him; therefore be it

RESOLVED, That our American Medical Association acknowledge with deep gratitude and sincere appreciation the lifelong work performed by Lawrence Monahan, MD, in service of the practice of medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Lawrence Monahan, MD, and adopt this resolution as an expression of deepest respect for our colleague and dear friend and our grief at his passing.

Lawrence Keith Monahan, MD
Introduced by Virginia

Whereas, Dr. Larry Monahan was not only a truly gifted clinician who served his community by his practice in general internal medicine in Roanoke, Virginia, he was a true physicians' advocate by his lifelong service to organized medicine at multiple levels; and

Whereas, Dr. Monahan served graciously as speaker and past president of the Medical Society of Virginia and an overall member of the Medical Society of Virginia for 43 years. Dr. Monahan taught with compassion and care at the University of Virginia School of Medicine and the Virginia College of Osteopathic Medicine as a clinical professor of internal medicine; and

Whereas, Dr. Monahan was well known at our American Medical Association and served honorably for many years as an AMA Delegate, serving 22 years in the Organized Medical Staff Section (OMSS); and

Whereas, Dr. Monahan was a Fellow of the American College of Physicians where he received the American Medical Association's Continuing Medical Education Award every year of his practice; and

Whereas, Larry was a gifted physician, an extraordinarily kind individual, and the best ballroom dancer; and

Whereas, He was known as an excellent teacher and a true believer in advocating for his patients; and

Whereas, His colleagues at our AMA shall miss his balanced perspective, leadership and contagious smile; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Lawrence K. Monahan to the medical profession, as well the encompassing Virginia community; and be it further

RESOLVED, That our AMA House of Delegates express its sympathy for the death of Dr. Monahan to his family and present them with a copy of this resolution.

Paul James O'Leary, MD
Introduced by Alabama

Whereas, Paul J. O'Leary, MD, a psychiatrist who practiced forensic psychiatry and child and adolescent psychiatry in Birmingham, Alabama, passed away suddenly on May 12, 2021; and

Whereas, Dr. O'Leary graduated summa cum laude from the University of Alabama in Birmingham with a bachelor's degree in Chemistry and later earned a master's degree in Health Informatics; and

Whereas, Dr. O'Leary graduated from the University of Alabama School of Medicine, and continued his post-graduate education through a psychiatry residency and a child and adolescent psychiatry fellowship at the University of Alabama School of Medicine; and

Whereas, Dr. O'Leary also completed a forensic psychiatry fellowship at Emory University; and

Whereas, Dr. O'Leary was highly respected by physicians and other healthcare professionals for his expertise and dedication to his patients; and

Whereas, Dr. O'Leary was active in many local and state psychiatric organizations, serving as president of the Birmingham Psychiatric Society and as a member of the Legislative and Public Affairs Committee for the Alabama Psychiatric Physicians Association; and

Whereas, Dr. O'Leary was also active in the Medical Association of the State of Alabama, where he served as chair of the Young Physicians' Section and the YPS member of the Board of Censors; and

Whereas, Dr. O'Leary was Vice Speaker of the Medical Association of the State of Alabama's House of Delegates and College of Counsellors at the time of his death; and

Whereas, Dr. O'Leary also served as the Speaker of the Assembly of the American Psychiatric Association; and

Whereas, Dr. O'Leary had been a member of the American Medical Association's House of Delegates since first attending as a Resident and Fellows Section Delegate; and

Whereas, Dr. O'Leary continued his contributions to the American Medical Association as an alternate delegate and delegate, representing the American Psychiatric Association from 2011 until the time of his death; and

Whereas, Dr. O'Leary was, above all else, a devoted husband and father to his wife, Malinda and his daughters Sophia and Sylvia and will be greatly missed by his parents, brother, family and friends; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Paul J. O'Leary's outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to Dr. O'Leary's family with an expression of the House's deepest sympathy.

Barbara A.P. Rockett, MD
Introduced by Massachusetts

Whereas, Dr. Barbara A.P. Rockett passed away on Tuesday, April 13, 2021, at the age of 89 and was a member of the American Medical Association for over 35 years and the Massachusetts Medical Society for over 40 years; and

Whereas, Dr. Rockett graduated from Tufts University School of Medicine in 1957; and

Whereas, Dr. Rockett was the first female surgical resident at Boston City Hospital and practiced general surgery; and

Whereas, Dr. Rockett was the beloved wife to Francis X. Rockett, MD, for 63 years and devoted mother of Francis X. Jr., Peter S., William E., Sean E., and Julie Rockett; and

Whereas, Dr. Rockett participated in organized medicine at the local, state, and national levels and dedicated herself to physicians and patients, whether performing house calls or speaking on the Senate floor, and she was stellar in all her abilities; and

Whereas, Dr. Rockett was chair of the AMA Council on Legislation, an active member of the House of Delegates for over 30 years, and president of the AMA Foundation; and

Whereas, Dr. Rockett was the first woman MMS president and the only president in modern time to serve two terms. During that time, Massachusetts was going through a medical malpractice crisis and Barbara was the lead. Being very effective, she was approached to stay on another term to continue her great work. Dr. Rockett secured malpractice reforms that are still benefiting our colleagues today; and

Whereas, Dr. Rockett received numerous awards over her illustrious career including the AMA Young Physicians' Young at Heart Award, the United Nations-USA Distinguished Service Award, the St. Francis Medal of Peace & Achievement, and the Tufts University Distinguished Service Award. Within the MMS, she received the Grant V. Rodkey, MD Award for Outstanding Contributions to Medical Education, sponsored by the Medical Student Section, the Presidential Citation for Outstanding Leadership, Award for Distinguished Service to the Massachusetts Medical Society, the Lifetime Achievement Award, the Norfolk District Medical Society's Clinician of the Year Award, and the Norfolk District Lifetime Achievement Award. Dr. Rockett was particularly proud of the most recent award named in her honor by the Committee on Young Physicians, the Barbara A. Rockett, MD, Early Career Physician Leadership Award, recognizing an early career physician who has demonstrated exemplary leadership in organized medicine, patient advocacy, and mentorship; and

Whereas, Dr. Barbara Rockett will be remembered as a courageous advocate for the most vulnerable people in society and as an articulate voice for ethical medical care. She is known as a champion physician who respects the life and dignity of every human being; therefore be it

RESOLVED, That our American Medical Association acknowledge the natural death and celebrate the life of our dear friend and colleague Barbara A.P. Rockett, MD; and be it further

RESOLVED, That expressions of condolences be forwarded with a copy of this memorial resolution to the Rockett family.

Calvin C.J. Sia, MD
Introduced by American Academy of Pediatrics

Whereas, The American Academy of Pediatrics (AAP) lost a respected and valued member when Calvin C.J. Sia MD, FAAP, passed away on August 19, 2020, in Honolulu, Hawaii; and

Whereas, Dr. Sia is the father of the medical home concept of care and Emergency Medical Services for Children Program; and

Whereas, Dr. Sia recognized challenges within his community and he sought ways to solve those challenges, and then brought those solutions not only to the community, but state, national, and even global level; and

Whereas, Dr. Sia advocated for children across the scope of pediatrics, including children with disabilities, emergency services for children, child abuse prevention and early periodic screening, diagnosis and treatment standards; and

Whereas, Dr. Sia served on the advisory committee for the Anne E. Dyson Foundation's initiative for pediatric residency training in community pediatrics; and

Whereas, Dr. Sia developed a home visiting program to prevent child abuse and neglect among children with special health care needs; and

Whereas, Dr. Sia introduced the Hawaii Healthy Start Home Visitors Program, he brought the model to the nation as Healthy Families America; and

Whereas, While Dr. Sia was president of the Hawaii Medical Association (1976-77), he worked on expanding the quality of emergency care provided to children with injuries where responders were not equipped for children, and urged the AAP to support a system of emergency medical care for children which resulted in the Emergency Medical Services for Children (EMS) Act, enacted in 1984; and

Whereas, Dr. Sia's passion and persistence brought our AMA and the AAP together to advance child health issues; and

Whereas, In 2007, the AAP, American Academy of Family Physicians, America College of Physicians and the America Osteopathic Association adopted the Joint Principles of the Patient-Centered Medical Home; and

Whereas, Throughout Dr. Sia's career he has earned numerous honors, including the Barbara Starfield Primary Care Leadership Award, Clifford G. Grulee Award, Job Lewis Smith Award, AMA Benjamin Rush Award, and the AMA/AAP Abraham Jacobi Award; and

Whereas, In 2005 the AAP Council on Community Pediatrics established the Cavin C.J. Sia Community Pediatrics Medical Home Leadership and Advocacy Award; therefore be it

RESOLVED, That our American Medical Association recognize and honor the many significant contributions made by Dr. Calvin C.J. Sia, MD, FAAP.

RESOLUTIONS

The Resolution Committee reviewed each resolution submitted for the Special Meeting and recommended that a resolution be considered or not considered based on its urgency and priority. The Resolution Committee recommended that the following resolutions not be considered, and the House of Delegates adopted those recommendations: 5, 8, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 101, 102, 103, 104, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 202, 203, 204, 205, 207, 208, 209, 211, 214, 220, 221, 222, 223, 224, 225, 231, 301, 302, 303, 306, 307, 312, 313, 315, 316, 317, 404, 405, 408, 409, 412, 416, 418, 419, 501, 502, 504, 505, 506, 507, 603, 604, 605, 606, 607, 701, 703, 704, 705, 708, 709, and 710.

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

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

1. DISCRIMINATION AGAINST PHYSICIANS IN TREATMENT WITH MEDICATION FOR OPIOID USE DISORDERS (MOUD)
Introduced by New York

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

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-95.913

RESOLVED, That our American Medical Association affirm that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder; and be it further

RESOLVED, That our AMA affirm that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including, but not limited to, methadone and buprenorphine; and be it further

RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including, but not limited to, methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student’s treatment plan includes MOUD; and be it further

RESOLVED, That our AMA survey physician health programs and state medical boards and report back about the prevalence of MOUD among physicians under monitoring for OUD, types of MAT utilized, and practice limitations or other punitive measures, if any, imposed solely on the basis of medication choice.

3. HEALTHCARE ORGANIZATIONAL POLICIES AND CULTURAL CHANGES TO PREVENT AND ADDRESS RACISM, DISCRIMINATION, BIAS AND MICROAGGRESSIONS
Introduced by American Academy of Pediatrics

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

HOD ACTION: ADOPTED
See Policy H-65.951

RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:
- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:
- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
  - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
  - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

4. AMA RESIDENT/FELLOW COUNCILOR TERM LIMITS
Introduced by Resident and Fellow Section

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

HOD ACTION: ADOPTED

RESOLVED, That our American Medical Association amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.5 Council on Ethical and Judicial Affairs.

6.5.7 Term.

6.5.7.2 Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 23 years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 23-year term; and be it further

RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.6 Council on Long Range Planning and Development.

6.6.3 Term.

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 23 years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.5 Vacancies.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 23-year term; and be it further

RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 23 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9. 3 Vacancies.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 23-year term.

6. ENSURING CONSENT FOR EDUCATIONAL PHYSICAL EXAMS ON ANESTHETIZED AND UNCONSCIOUS PATIENTS
Introduced by Resident and Fellow Section

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

HOD ACTION: ADOPTED
See Policies H-140.828 and H-320.951

RESOLVED, That our American Medical Association oppose performing physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior informed consent to do so; and be it further

RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia; and be it further

RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams; and be it further

RESOLVED, That our AMA reaffirm policy H-320.951, "AMA Opposition to "Procedure-Specific" Informed Consent."

7. NONCONSENSUAL AUDIO/VIDEO RECORDING AT MEDICAL ENCOUNTERS
Introduced by Virginia, New Jersey, District of Columbia, Louisiana, American Association of Clinical Urologists, American Urological Association, Maryland

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

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent.

9. SUPPORTING WOMEN AND UNDERREPRESENTED MINORITIES IN OVERCOMING BARRIERS TO POSITIONS OF MEDICAL LEADERSHIP AND COMPETITIVE SPECIALTIES
Introduced by Illinois

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

HOD ACTION: ADOPTED
See Policies H-200.951 and D-200.975

RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; and be it further

RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields:

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce
Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and take active measures to support medical students who identify with groups

underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce; and be it further

RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics:

1. Identify with group(s) underrepresented and disadvantaged in medicine
2. Are from medically underserved areas
3. Are first generation college graduates

as a mechanism to create more exposure to leadership and networking opportunities for these students.

15. OPPOSITION TO THE CRIMINALIZATION AND UNDUE RESTRICTION OF EVIDENCE-BASED GENDER-AFFIRMING CARE FOR TRANSGENDER AND GENDER-DIVERSE INDIVIDUALS
Introduced by Medical Student Section, GLMA: Health Professionals Advancing LGBTQ Equality

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

HOD ACTION: ADOPTED
See Policy H-185.927

RESOLVED, That our American Medical Association amend Policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," by addition and deletion to read as follows:

H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria"
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

22. MATERNAL LEVELS OF CARE STANDARDS OF PRACTICE
Introduced by Michigan

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

HOD ACTION: POLICY H-245.971 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION
See Policy H-245.971

RESOLVED: That our American Medical Association amend existing Policy D-420.993, "Disparities in Maternal Mortality," by addition and deletion to read as follows:

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; ~~and~~ (4) will advocate for the adoption of national standards of practice by birthing centers across the country to help improve maternal health; and (5) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

23. PANDEMIC ETHICS AND THE DUTY OF CARE
Introduced by Young Physicians Section

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

HOD ACTION: ADOPTED
See Policy D-130.960

RESOLVED, That our Council on Ethical and Judicial Affairs reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.

24. AMA BYLAWS LANGUAGE ON AMA YOUNG PHYSICIANS SECTION GOVERNING COUNCIL ELIGIBILITY
Introduced by Young Physicians Section

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

HOD ACTION: ADOPTED AS FOLLOWS

RESOLVED, that the American Medical Association amend the relevant AMA Bylaws to: (1) clarify eligibility of membership in the YPS to be until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes later, and (2) reflect that a person who is elected to the Young Physician Section chair-elect position when an eligible member of the Section can complete the chair-elect, chair, and immediate past chair positions even if they have aged out of the Section.

REFERENCE COMMITTEE A

105. EFFECTS OF TELEHEALTH COVERAGE AND PAYMENT PARITY ON HEALTH INSURANCE PREMIUMS
Introduced by Florida

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association conduct or commission a study on the effect that telemedicine services have had on health insurance premiums, focusing on the differences between states that had telehealth payment parity provisions in effect prior to the pandemic versus those that did not, and report back at the 2021 Interim Meeting of the AMA House of Delegates.

121. MEDICAID DIALYSIS POLICY FOR UNDOCUMENTED PATIENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-290.957

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid.

122. DEVELOPING BEST PRACTICES FOR PROSPECTIVE PAYMENT MODELS
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association study and identify best practices for financially viable models for prospective payment health insurance, including but not limited to appropriately attributing and allocating patients to physicians, elucidating best practices for systems with multiple payment contracts, and determining benchmarks for adequate infrastructure, capital investment, and models that accommodate variations in existing systems and practices; and be it further

RESOLVED, That our AMA use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models.

123. MEDICARE ELIGIBILITY AT AGE 60
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED FOR REPORT AT NOVEMBER 2021 MEETING OF THE HOD

RESOLVED, That our American Medical Association advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60.

REFERENCE COMMITTEE B

201. ENSURING CONTINUED ENHANCED ACCESS TO HEALTHCARE VIA TELEMEDICINE AND TELEPHONIC COMMUNICATION

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 201
See Policy D-480.961

RESOLVED, That our American Medical Association advocate that the HIPAA enforcement moratorium for telehealth services be extended by at least 365 days after the end of the COVID-19 Public Health Emergency, during which time physicians and other affected parties shall not be subject to HIPAA audits and other HIPAA enforcement activity relative to telehealth.

206. REDEFINING THE DEFINITION OF HARM
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 212
See Policy D-315.972

RESOLVED, That our American Medical Association advocate to the Office for Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians

under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient; and be it further

RESOLVED, That our AMA advocate that the Office for Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health; and be it further

RESOLVED, Our AMA continue to urge the Department of Health and Human Services (HHS)'s Office of the National Coordinator for Health Information Technology (ONC) and its Office of Inspector General (OIG) to leverage their enforcement discretion that would afford medical practices additional compliance flexibilities; and be it further

RESOLVED, That our AMA urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.

210. RANSOMWARE AND ELECTRONIC HEALTH RECORDS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-478.960

RESOLVED, That our American Medical Association adopt policy acknowledging that healthcare data interruptions are especially harmful due to potential physical harm to patients and calling for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients; and be it further

RESOLVED, That our AMA advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law; and be it further

RESOLVED, That our AMA encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion; and be it further

RESOLVED, That our AMA advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection, and be it further

RESOLVED, That our AMA seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation.

212. ONC's INFORMATION BLOCKING REGULATIONS
Introduced by American Academy of Dermatology, College of American Pathologists, Missouri, Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, Pennsylvania, Society for Investigative Dermatology, South Carolina, Iowa, American Society for Dermatologic Surgery

Resolution 212 considered with Resolution 206. See Resolution 206.

RESOLVED, That our American Medical Association advocate for additional time and compliance leeway for physicians by urging the Office of the National Coordinator for Health Information Technology (ONC) to broaden and relax their current regulatory requirements based on the following critical enumerated requests:

a. Urge the ONC to strike the right balance between the demands and distress caused by the COVID-19 public health emergency (PHE) and its interoperability rule objectives.

b. Urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.
c. Urge the ONC, through an interim final rule moratorium, to delay the current applicability date of information blocking provisions until 12 months after the PHE is officially declared over, affording small and medium-sized medical practices time to recover and prepare.
d. Urge the Department of Health and Human Services (HHS)'s ONC and their OIG to propose future enforcement discretion that would afford small and medium-sized medical practices further compliance flexibilities given their lack of resources.
e. Call on the HHS's ONC and OIG in future enforcement rulemaking to propose corrective action and further technical guidance rather than imposing fines or penalties.
f. Urge the ONC to broaden and relax its Patient Harm Exception through subregulatory revisions that would include patients' emotional and mental distress to the current and narrow definition of this exception.
g. Call on the ONC to develop and offer more meaningful educational guidance, practical resources, and technical assistance to physician practices to help them meet their compliance efforts, patient care obligations and documentation requirements.

213. CMMI PAYMENT REFORM MODELS
Introduced by Association for Clinical Oncology, American Academy of Ophthalmology, American College of Rheumatology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-385.950

RESOLVED, That our American Medical Association continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; and be it further

RESOLVED, That our AMA advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and be it further

RESOLVED, That our AMA advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties.

215. EXEMPTIONS TO WORK REQUIREMENTS AND ELIGIBILITY EXPANSIONS IN PUBLIC ASSISTANCE PROGRAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-440.919

RESOLVED, That our American Medical Association support elimination of work requirements used as eligibility criteria in public assistance programs, including Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF); and be it further

RESOLVED, That our AMA support states' ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program; and be it further

RESOLVED, That our AMA work with state medical societies to encourage states to establish express lane eligibility (ELE) programs that use eligibility data from the maximum number of Express Lane Agencies (ELAs) feasible, which

include SNAP, TANF, and other programs as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children's Health Insurance Program (CHIP).

216. OPPOSITION TO FEDERAL BAN ON SNAP BENEFITS FOR PERSONS CONVICTED OF DRUG RELATED FELONIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-440.809

RESOLVED, That our American Medical Association oppose any lifetime ban on SNAP benefits imposed on individuals convicted of drug-related felonies.

217. AMENDING H-150.962, QUALITY OF SCHOOL LUNCH PROGRAM TO ADVOCATE FOR THE EXPANSION AND SUSTAINABILITY OF NUTRITIONAL ASSISTANCE PROGRAMS DURING COVID-19
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-150.962

RESOLVED, That our American Medical Association amend Policy H-150.962, "Quality of School Lunch Program," by addition as follows:

H-150.962, "Quality of School Lunch Program"

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
3. Our AMA support adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic.

218. ADVOCATING FOR ALTERNATIVES TO IMMIGRANT DETENTION CENTERS THAT RESPECT HUMAN DIGNITY

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY H-350.955 AMENDED AND TITLE CHANGED IN LIEU OF RESOLUTION 218
See Policy H-350.955

H-350.955, "~~Care of Women and Children in Family~~ Policy Regarding Immigration Detention"
1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

219. OPPOSE TRACKING OF PEOPLE WHO PURCHASE NALOXONE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 219
See Policies H-95.932, H-315.983, H-440.813, and D-120.930

RESOLVED, That our AMA oppose any policies, regulations, or laws that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked, monitored, or utilized for non-clinical or non-public health care purposes; and be it further

RESOLVED, That our AMA advocate for availability of naloxone as an over-the-counter medication; and be it further

RESOLVED, That AMA Policies H-315.983, H-440.813, and H-95.932 be reaffirmed.

226. INTEREST-BASED DEBT BURDEN ON MEDICAL STUDENTS AND RESIDENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-305.925

RESOLVED, That our American Medical Association strongly advocate for the passage of legislation to allow medical students, residents, and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

227. AUDIO-ONLY TELEHEALTH FOR RISK ADJUSTED PAYMENT MODELS
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-480.962

RESOLVED, That our American Medical Association advocate that diagnoses coded for audio-only telehealth encounters be included in risk adjusted payment models; and be it further

RESOLVED, Our AMA advocate for coverage and payment of audio-only services in appropriate circumstances to ensure equitable coverage for patients who need access to telecommunication services but who do not have access to two-way audio-visual technology.

228. COVID-19 VACCINATION ROLLOUT TO EMERGENCY DEPARTMENTS AND URGENT CARE FACILITIES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-440.875, D-440.918 and D-440.921

RESOLVED, That our AMA work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent care facilities during the COVID-19 public health emergency; and be it further

RESOLVED, That Policies H-440.875 and D-440.921 be reaffirmed.

229. CLASSIFICATION AND SURVEILLANCE OF MATERNAL MORTALITY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-60.909, H-315.983, H-420.948, H-430.986, and D-420.993

RESOLVED, That our AMA encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates while ensuring appropriate nondiscrimination and privacy safeguards; and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process while ensuring appropriate nondiscrimination and privacy safeguards; and be it further

RESOLVED, That Policies H-60.909, H-315.983, H-430.986, and D-420.993 be reaffirmed.

230. CONSIDERATIONS FOR IMMUNITY CREDENTIALS DURING PANDEMICS AND EPIDEMICS
Introduced by Medical Student Section

Resolution 230 was considered with Board of Trustees Report 18.
See Board of Trustees Report 18.

RESOLVED, That our AMA:

(1) oppose the implementation of natural immunity credentials, which give an individual differential privilege on the basis of natural immunity after non-vaccine exposure status to a pathogen, and

(2) caution that any implementation of vaccine-induced immunity credentials, which give an individual differential privilege on the basis of acquired immunity after receiving a vaccine, must strongly consider potential consequences on social inequity, including, but not limited to,
   i. continued marginalization of communities historically harmed or ignored by the healthcare system,
   ii. isolation of populations who may be ineligible for or unable to access vaccines,
   iii. barriers preventing immigration or travel from countries with low access to vaccines and the need to offer a vaccine upon arrival to anyone entering the US from another country, and
   iv. privacy of and accessibility to any systems used to implement vaccine-induced immunity passports

232. CLASSIFICATION AND SURVEILLANCE OF MATERNAL MORTALITY
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-315.973

RESOLVED, That our American Medical Association advocate to prohibit the use of patient/customer information collected by retail pharmacies for COVID-19 vaccination scheduling and/or the vaccine administration process for commercial marketing or future patient recruiting purposes, especially any targeting based on medical history or conditions; and be it further

RESOLVED, That our AMA oppose the sale or transfer of medical history data and contact information accumulated through the scheduling or provision of government-funded vaccinations to third parties for use in marketing or advertising.

233. NON-PHYSICIAN TITLE MISAPPROPRIATION
Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery, Arizona, Arkansas, California, District of Columbia, Florida, Mississippi, New Jersey, New York, Oklahoma, South Carolina, Texas, American Society of Anesthesiologists, American Academy of Allergy Asthma and Immunology, American Society of Dermatopathology, American Society of Plastic Surgeons, Kansas, Missouri, American Society of Ophthalmic Plastic and Reconstructive Surgery, American College of Mohs Surgery, American Academy of Facial Plastic and Reconstructive Surgery, Kentucky, American Academy of Cosmetic Surgery, International Society of Hair Restoration Surgery, American Academy of Ophthalmology, American Association of Clinical Urologists, American Urological Association, Pennsylvania

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-405.977

RESOLVED, That our American Medical Association actively oppose the American Academy of Physician Assistants' (AAPA's) recent move to change the official title of the profession from "Physician Assistant" to "Physician Associate"; and be it further

RESOLVED, That our AMA actively advocate that the stand-alone title "physician" be used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic medicine (DOs), and not be used in ways that have the potential to mislead patients about the level of training and credentials of non-physician health care workers.

REFERENCE COMMITTEE C

304. DECREASING FINANCIAL BURDENS ON RESIDENTS AND FELLOWS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
ADDITIONAL RESOLVE REFERRED
See Policies H-150.949 and H-310.912

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties; and be it further

RESOLVED, That our AMA work with relevant stakeholders to define "access to food" for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals; and be it further

RESOLVED, That the Residents and Fellows' Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs; and be it further

RESOLVED, That the AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition and deletion to read as follows:

5. Our AMA partner with ACGME and other relevant stakeholders to encourage~~s~~ training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services. ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.~~

Editor's note: Following resolve referred:

RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare.

305. NON-PHYSICIAN POST-GRADUATE MEDICAL TRAINING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
ADDITIONAL RESOLVES REFERRED
See Policies H-310.912, H-310.916 and D-275.949

RESOLVED, That our American Medical Association believe that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels); and be it further

RESOLVED, That our AMA study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate, and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education; and be it further

RESOLVED, That Policy H-310.916 be reaffirmed.

RESOLVED, That Policy H-310.912 "Resident and Fellow Bill of Rights," be amended by addition and deletion to read as follows:

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows ~~should expect supervision by physicians and non-physicians~~ must be ultimately supervised by physicians who are adequately qualified and ~~which~~ allow~~s~~ them to assume progressive responsibility appropriate to their level of education, competence, and experience. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~ In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate; and be it further

RESOLVED, That our AMA 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.

Editor's note: Following resolves referred:

RESOLVED, That our AMA amend Policy H-275.925 "Protection of the Titles 'Doctor,' 'Resident' and 'Residency'," by addition and deletion to read as follows:

Our AMA: (1) recognizes that when used in the healthcare setting, specific terms describing various levels of allopathic and osteopathic physician training and practice (including the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," and "attending") represent the completion of structured, rigorous, medical education undertaken by physicians (as defined by the American Medical Association in H-405.951, "Definition and Use of the Term Physician"), and must be reserved for describing only physician roles; (2) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (3) supports and develops model state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including the level of ~~make it a~~ felony ~~to~~ for misrepresenting oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," or "attending" in a healthcare setting except by physicians.

RESOLVED, That our AMA oppose non-physician healthcare providers who seek to possess the ability to practice medicine without physician supervision from holding a seat on the board of an organization that regulates and/or provides oversight of physician accreditation, certification, credentialing, and undergraduate and graduate medical education, as it represents a conflict of interest.

308. RESCIND USMLE STEP 2 CS AND COMLEX LEVEL 2 PE EXAMINATION REQUIREMENT FOR MEDICAL LICENSURE

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 308
See Policy D-295.988

RESOLVED, That Policy D-295.988 be reaffirmed in lieu of Resolution 308.

309. SUPPORTING CHILD CARE FOR HEALTH CARE PROFESSIONALS
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-200.974

RESOLVED, That our American Medical Association work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees).

310. UNREASONABLE FEES CHARGED BY ABMS MEMBER BOARDS
Introduced by

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-275.954

RESOLVED, That our American Medical Association work with the American Board of Medical Specialties Boards (ABMS) and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

311. STUDENT LOAN FORGIVENESS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 311
See Policy H-305.925

RESOLVED, That Policy H-305.925 be reaffirmed in lieu of Resolution 311.

314. STANDARD PROCEDURE FOR ACCOMMODATIONS IN USMLE AND NBME EXAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association collaborate with medical licensing organizations to facilitate a timely accommodations application process; and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities.

318. THE IMPACT OF PRIVATE EQUITY ON MEDICAL TRAINING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-310.947

RESOLVED, That our American Medical Association work with relevant stakeholders including specialty societies and the Accreditation Council for Graduate Medical Education to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates, with possible publication of their findings.

319. THE EFFECT OF THE COVID-19 PANDEMIC ON GRADUATE MEDICAL EDUCATION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-310.946

RESOLVED, That our American Medical Association work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and be it further

RESOLVED, That our AMA urge ACGME and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the drastic educational barriers confronted during the COVID-19 pandemic.

REFERENCE COMMITTEE D

401. UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES
Introduced by Washington

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: FIRST RESOLVE REFERRED FOR REPORT AT 2021 INTERIM MEETING
SECOND RESOLVE REFERRED

RESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:

1. a list of all essential public health services that should be provided in every jurisdiction of the United States;
2. a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;
3. a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and
4. a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction; and be it further

RESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services.

402. MODERNIZATION AND STANDARDIZATION OF PUBLIC HEALTH SURVEILLANCE SYSTEMS

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTION 402
See Policy H-440.813

RESOLVED, That our American Medical Association: (1) advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments and (2) support data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations; and be it further

RESOLVED, That Policy H-440.813, “Public Health Surveillance,” be reaffirmed.

403. CONFRONTING OBESITY AS A KEY CONTRIBUTOR TO MATERNAL MORTALITY, RACIAL DISPARITY, DEATH FROM COVID-19, UNAFFORDABLE HEALTH CARE COST WHILE RESTORING HEALTH IN AMERICA
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association advocate for a National Task Force to be led by the medical profession along with other stakeholders to confront the epidemic of obesity primarily among minority women, prior to, during and after pregnancy, thereby reducing maternal mortality & morbidity rates, racial disparity in access to care, death from COVID-19 infection and healthcare costs while restoring health in our nation with report back at the 2021 Interim Meeting and beyond.

406. ADDRESSING UNDERLYING HEALTH CONDITIONS ASSOCIATED WITH RISK FOR SEVERE COVID-19
Introduced by District of Columbia, American College of Cardiology, Obesity Medicine Association, American Association of Clinical Endocrinologists

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-440.807

RESOLVED, That our American Medical Association urge federal, state, and municipal leaders to prominently note in their COVID-19 public health advisories the urgent need for individuals with underlying health conditions to consult with their physicians to assess their health status and institute (or resume) appropriate treatment.

407. IMPACT OF SARS-COV-2 PANDEMIC ON POST-ACUTE CARE SERVICES AND LONG-TERM CARE AND RESIDENTIAL FACILITIES
Introduced by Oregon

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-280.983

RESOLVED, That our American Medical Association collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these Post-Acute Care (PAC) and long-term care (LTC) facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

a) Planning for adequate funding and access to resources;
b) Planning for emergency staffing of health care and maintenance personnel;
c) Planning for ensuring safe working conditions of PAC and LTC staff; and
d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis.

410. CALL FOR INCREASED FUNDING, RESEARCH, AND EDUCATION FOR POST VIRAL SYNDROMES

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 410 AND 413
See Policy D-460.965

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID") and other novel post-viral syndromes as distinct diagnoses; and be it further

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequalae associated with viral infections, such as COVID-19; and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequalae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face.

411. USE OF FACE MASKS BY INDIVIDUALS TO REDUCE THE SPREAD OF RESPIRATORY PATHOGENS

Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS TITLE CHANGED
See Policy H-440.806

RESOLVED, That our American Medical Association support the ongoing use of face masks for those wishing to protect themselves and those around them from respiratory tract infections; and be it further

RESOLVED, That our AMA promulgate scientific information to both patients and physicians about the benefits of masks to protect patients, especially those at high risk, to reduce exposure to and spread of respiratory pathogens.

413. CALL FOR INCREASED FUNDING AND RESEARCH FOR POST VIRAL SYNDROMES

Introduced by Medical Student Section

Resolution 413 was considered with Resolution 410. See Resolution 410.

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue (ME/CFS); and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequalae associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequalae associated with COVID-19, including but not limited to

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face.

414. CALL FOR IMPROVED PERSONAL PROTECTIVE EQUIPMENT DESIGN AND FITTING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-440.810

RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

415. AMENDING H-440.847 TO CALL FOR NATIONAL GOVERNMENT AND STATES TO MAINTAIN PERSONAL PROTECTIVE EQUIPMENT AND MEDICAL SUPPLY STOCKPILES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-440.847

RESOLVED, That our American Medical Association amend Policy H-440.847 by addition and deletion to read as follows:

H-440.847, "Pandemic Preparedness ~~for Influenza~~"

In order to prepare for a ~~potential influenza~~ pandemic, our AMA:

(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a~~n influenza~~ a pandemic or other serious public health emergency;

(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;

(3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;

(~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel ~~physicians and medical office staff~~ in ~~ambulatory~~ direct patient care settings;

(4~~5~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue ~~take immediate action~~ to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel ~~professionals~~, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and

(b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care provider;
(7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n influenza~~ pandemic in the United States.

417. AMENDMENT TO FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD, H-150.925
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-150.925

RESOLVED, That our American Medical Association amend Policy H-150.925, "Food Environments and Challenges Accessing Healthy Food," by addition and deletion as follows,

H-150.925, "Food Environments and Challenges Accessing Healthy Food"
Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.

420. IMPACT OF SOCIAL NETWORKING SERVICES ON THE HEALTH OF ADOLESCENTS

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 420
See Policy D-478.965

RESOLVED, That Policy D-478.965, "Addressing Social Media Usage and its Negative Impacts on Mental Health," be amended by addition and deletion in lieu of Resolution 420 to read as follows:

Addressing Social Media and Social Networking Usage and its ~~Negative~~ Impacts on Mental Health
Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; ~~and~~ (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.

421. MEDICAL AND PUBLIC HEALTH MISINFORMATION IN THE AGE OF SOCIAL MEDIA
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
ADDITIONAL RESOLVE REFERRED
See Policies D-440.915 and D-440.921

RESOLVED, That our AMA encourage social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; and be it further

RESOLVED, That our AMA encourage social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; and be it further

RESOLVED, That our AMA continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and be it further

RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information; and be it further

RESOLVED, That our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

D-440.921, "An Urgent Initiative to Support COVID-19 Vaccination and Information Programs"
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.

Editor's note: Following resolve referred:

RESOLVED, That our AMA study and consider public advocacy of modifications to Section 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:

any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, excessively violent, harassing, pose risk to public health, or be otherwise objectionable, whether or not such material is constitutionally protected.

REFERENCE COMMITTEE E

503. ACCESS TO EVIDENCE-BASED ADDICTION TREATMENT IN CORRECTIONAL FACILITIES
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-430.986 and H-430.987

RESOLVED, That our American Medical Association amend Policy H-430.987, "Opiate Replacement Therapy Programs in Correctional Facilities," by addition and deletion to read as follows:

H-430.987, "~~Opiate Replacement Therapy Programs~~ Medications for Opioid Use Disorder in Correctional Facilities"

1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement therapy (ORT)~~ medications for opioid use disorder (OUD) as ~~an effective therapy in treating opiate addicted~~ the standard of care for persons with OUD who are incarcerated; and (b) ~~ORT for opiate addicted~~ medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations, including but not limited to, ~~the National Commission on Correctional Health Care and~~ the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that ~~encourage~~ require correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use disorder~~, including initiation and continuation of ~~opioid replacement therapy~~ medications for OUD, in conjunction with ~~counseling~~ psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting.
3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment ~~medication assisted therapy~~.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

RESOLVED, That our AMA amend Policy H-430.986, "Health Care While Incarcerated," by addition and deletion to read as follows:

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA ~~supports~~ advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA ~~urges~~ advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.~~, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.~~
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8.~~7~~. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of ~~incarcerated~~ women and adolescent females who are incarcerated, including gynecological care and obstetrics care for ~~pregnant and postpartum women~~ individuals who are pregnant or postpartum.
9.~~8~~. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both ~~inmates~~ individuals who are incarcerated and staff in correctional facilities.
10.~~9~~. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance ~~ab~~use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our American Medical Association advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

REFERENCE COMMITTEE F

601. $100 MEMBER ANNUAL DUES PAYMENT THROUGH 2023
Introduced by Mississippi, New Jersey, Puerto Rico, South Carolina, Oklahoma

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association adjust dues to $100 per year for a trial period of two years for actively practicing physicians and senior physicians.

602. TIMELY PROMOTION AND ASSISTANCE IN ADVANCE CARE PLANNING AND ADVANCE DIRECTIVES
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-140.953

RESOLVED, That our American Medical Association begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives; and be it further

RESOLVED, That our AMA encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components

of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families; and be it further

RESOLVED, That our AMA strongly encourage all physicians of relevant specialties providing primary or/and advanced illness care to include advance care planning as a routine part of their patient care protocols when indicated, including advance directive documentation in patients' medical records (including electronic medical records), as a suggested standard health maintenance practice; and be it further

RESOLVED, That our AMA collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions, and to promote the adoption and use of electronic systems to make patients' advance directives readily available to treatment teams regardless of location; and be it further

RESOLVED, That our AMA actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day.

608. PROMOTING EQUITABLE RESOURCE DISTRIBUTION GLOBALLY IN RESPONSE TO THE COVID-19 PANDEMIC

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 608, 609, 610 AND 611
See Policy D-440.917

RESOLVED, That our AMA, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources; and be it further

RESOLVED, That our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support; and be it further

RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis; and be it further

RESOLVED, That our AMA support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including:

1. A temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections;
2. Technological transfers relevant for vaccine production;
3. Other support, financial and otherwise, necessary to scale up global vaccine manufacturing;
4. Measures that ensure the safety and efficacy of products manufactured by such means.

609. COVID-19 CRISIS IN ASIA
Introduced by International Medical Graduates Section, New York

Resolution 609 was considered with Resolutions 608, 610 and 611. See Resolution 608.

RESOLVED, That our American Medical Association advocate the U.S. government to continue providing all possible assistance including surplus vaccines and vaccines that have not had Emergency Use Authorization to the citizens of countries with precarious situations in this humanitarian crisis including but not limited to India, Nepal, Thailand, Myanmar, etc.; and be it further

RESOLVED, That our AMA explore all possible assistance through the World Medical Association and the World Health Organization for the citizens of countries where the cases of COVID-19 have been exponentially increasing; and be it further

RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian crisis.

610. PROMOTING EQUITY IN GLOBAL VACCINE DISTRIBUTION
Introduced by Medical Student Section

Resolution 610 was considered with Resolutions 608, 609 and 611. See Resolution 608.

RESOLVED, That our American Medical Association amend Policy H-250.988, "Low Cost Drugs to Poor Countries during Times of Pandemic Health Crises," by addition and deletion to read as follows:

H-250.988, "Aid ~~Low-Cost Drugs~~ to ~~Poor~~ Low- And Middle-Income Countries During Epidemics and Pandemics ~~Times Of Pandemic Health Crises~~"

Our AMA will: (1) ~~encourages pharmaceutical companies to provide~~ to work with governmental and appropriate regulatory authorities to encourage (a) the prioritization of equity when providing low cost or free medications, including therapeutics and vaccines, to countries; (b) the temporary waiver of intellectual property protections for necessary medications and other countermeasures; and (c) sharing of equipment, materials, scientific methods, and technological information, to facilitate production and distribution of necessary medications during epidemics and pandemics ~~during times of pandemic health crises~~; and (2) shall work with the World Health Organization (WHO), UNAIDS, and similar organizations that provide comprehensive assistance, including health care, to ~~poor~~ low- and middle-income countries in an effort to improve public health and national stability.

611. COVID-19 CRISIS IN INDIA
Introduced by American Association of Physicians of Indian Origin, New Jersey, Michigan, Virginia, Maryland, Pennsylvania

Resolution 611 was considered with Resolutions 608, 609 and 610. See Resolution 608.

RESOLVED, That our American Medical Association urge the U.S. government to provide all possible assistance including surplus vaccines and vaccines that have not had emergency use authorization to the citizens of India and other countries in a similar situation in this humanitarian crisis; and be it further

RESOLVED, That our AMA advocate for all possible assistance through WMA and WHO for government and the citizens of India and other countries in a similar situation; and be it further

RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians and ethnic organizations assisting in this humanitarian crisis.

REFERENCE COMMITTEE G

702. ADDRESSING INFLAMMATORY AND UNTRUTHFUL ONLINE RATINGS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews.

706. PREVENT MEDICARE ADVANTAGE PLANS FROM LIMITING CARE
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-285.959

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and be it further

RESOLVED, That our AMA advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

707. FINANCIAL INCENTIVES FOR PATIENTS TO SWITCH TREATMENTS
Introduced by American College of Rheumatology, American Gastroenterological Association, American Academy of Ophthalmology, American College of Gastroenterology, American Academy of Dermatology, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-185.976

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing payments to patients as financial incentives to switch treatments from those recommended by their physicians; and be it further

RESOLVED, That our AMA support legislation that would ban insurer policies that provide payments to patients as financial incentives to switch treatments from those recommended by their physicians, and will oppose legislation that would make these practices legal; and be it further

RESOLVED, That our AMA engage with state and federal regulators to alert them to identified policies providing payments to patients as financial incentives who switch to payer-preferred drugs, and encourage state and federal regulators to prohibit and/or discourage such policies.

711. OPPOSITION TO ELIMINATION OF "INCIDENT-TO" BILLING FOR NON-PHYSICIAN PRACTITIONERS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-160.915

RESOLVED, That our American Medical Association advocate against efforts to eliminate "incident-to" billing for non-physician practitioners among private and public payors.