Pursuant to our Medical Student Section IOP 9.3, the following informational report details the actions taken by your Medical Student Section Delegates, MSS regional delegates and alternate delegates, and MSS Caucus (hereby described as "MSS Delegates") at the June 2021 Meeting. MSS Delegates are advised to take a position on a business item where guided by our Section’s Compendium of Actions ("internal policy"). Should no relevant internal policy exist, our Caucus may decide to vote to take a stance based on internal discussion. Those particular instances are detailed in the report below.

RESOLUTIONS INTRODUCED BY THE MEDICAL STUDENT SECTION

1. Res. 015 - Opposition to the Criminalization and Undue Restrictions of Evidence-Based Gender-Affirming Care for Transgender and Gender Diverse Individuals

   MSS Action: MSS Delegates supported the resolution. Friendly amendments were proposed and MSS Delegates supported the amended language as follows.
   
   HOD Action: Resolution 015 was adopted as follows (Updated Policy H-185.927):
   
   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; (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.

2. Res. 123 - Medicare Eligibility at Age 60

   MSS Action: MSS Delegates supported the original language in Resolution 123. The Reference Committee recommended referral for study. MSS Delegates extracted the resolution to try to adopt it or to ask for an earlier report back date.
   
   HOD Action: Refer for study, with report back at the November 2021 meeting.

3. Res. 215 - Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs

   MSS Action: MSS Delegates supported the resolution. Friendly amendments were proposed and MSS Delegates supported the amended language as follows.
HOD Action: Adopt as amended as follows (Updated Policy D-440.919):

Our AMA: (1) supports reduction and elimination of work requirements applied to the used as eligibility criteria in public assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF); (2) supports 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 (3) will 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).

4. Res. 216 - Opposition to Federal Ban of SNAP Benefits for Persons Convicted of Drug-Related Felonies

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 216 was adopted as follows (New Policy H-440.809):

Our AMA will oppose any lifetime ban on SNAP benefits imposed on individuals convicted of drug-related felonies.

5. Res. 217 - Amending H-150.962, Quality of School Lunch Program, to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs during COVID-19

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 217 was adopted as follows (Updated Policy H-150.962):

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 supports adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic.

6. Res. 218 - Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity

MSS Action: MSS Delegates supported amendments offered by the Reference Committee and the language as follows.

HOD Action: Policy H-350.955 was amended in lieu of Resolution 218, as follows:

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.

7. **Res. 219 - Oppose Tracking of People who Purchase Naloxone**

   **MSS Action:** MSS Delegates were not in support of the reaffirmation of this resolution, which was initially offered by the reference committee. This resolution was extracted and your MSS Delegates offered amendments to include some of the original language of this resolution. Your MSS Delegates supported the final resolution as below.

   **HOD Action:** Resolution 219 was adopted as follows (New Policy D-120.930)

   Our AMA will: (1) 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 (2) advocate for availability of naloxone as an over-the-counter medication.

   Policies H-315.983, H-440.813, and H-95.932 were reaffirmed.

8. **Res. 229 - Classification and Surveillance of Maternal Mortality**

   **MSS Action:** MSS Delegates supported the language as initially transmitted during the Reference Committee.

   **HOD Action:** Resolution 229 was adopted as follows (New Policy H-420.948)

   Our AMA will: (1) 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 (2) 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.

   Policies D-420.993, H-430.983, and H-60.909 were reaffirmed.

9. **Res. 230 - Considerations for Immunity Credentials during Pandemics and Epidemics**

   **MSS Action:** MSS Delegates supported the recommendations of the Reference Committee in order to incorporate our original item. There were amendments proposed in order to better encompass immigrants and the unique effects that vaccine credentials would have on this population. Your MSS Delegates supported these amendments and the clause was ultimately referred.
HOD Action: BOT Report 18 was adopted as follows in lieu of Resolution 230 (New Policy H-440.808)

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

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials:
   a. vaccine is widely accessible;
   b. equity-centered privacy protections are in place to safeguard data collected from individuals;
   c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and
   d. credentials address the situation of individuals for whom vaccine is medically contraindicated.

2. Recommends that decisions to mandate COVID-19 vaccination be made only:
   a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
   b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
   c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
   d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.

3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust.

4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection.

The following clause was referred for decision:

Recommends that vaccine credentials are not used to prevent immigration, or voluntary repatriation, that vaccines be offered upon arrival, and that vaccination is required to be accepted prior to entry in the US, and that vaccine mandates are uniformly applied regardless of citizenship.


MSS Action: MSS Delegates supported the resolution as proposed and were in agreement with referral to decision when it was proposed on the House floor.

HOD Action: Resolution 314 was referred for decision.

11. Res. 413 - Call for Increased Funding and Research for Post-Viral Syndromes
MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee. Amendments were proposed that combined this resolution with an item on a similar topic, which MSS Delegates found friendly and supported.

HOD Action: Resolution 413 was combined with Resolution 410 and adopted as follows (New Policy D-460.965):

Our AMA: (1) supports 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; (2) will 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; (3) will provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; and (4) will collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face.

12. Res. 414 - Call for Improved PPE Design and Fitting

MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee.

HOD Action: Resolution 414 was adopted as follows (Updated Policy H-440.810, addition of clause 7):

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.

2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.

3. Our AMA will AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.

4. Our AMA supports physicians and health care professionals in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.

5. Our AMA supports a physician’s right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

13. Res. 415 - Amending H-440.847, to Call for National Government and States to Maintain PPE and Medical Supply Stockpiles

**MSS Action:** MSS Delegates supported the resolution as it was originally transmitted.

**HOD Action:** Resolution 415 was adopted as follows (Updated Policy H-440.847):

In order to prepare for a 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 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, anti-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 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;

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

(6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, 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 vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.

14. Res. 417 - Amendment to Food Environments and Challenges Accessing Healthy Food

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 417 was adopted as follows (Updated Policy H-150.925):

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports 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.

15. Res. 421 - Medical Misinformation in the Age of Social Media

MSS Action: MSS Delegates supported the resolution.

HOD Action: The final resolved clause of Resolution 421 was referred while the remainder of the clauses were adopted as follows (New Policy D-440.915):

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.

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.

16. Res. 610 - Promoting Equity in Global Vaccine Distribution

MSS Action: MSS Delegates supported the resolution. The resolution was considered with other similar resolutions (608, 609, and 611). MSS Delegates proposed an amendment to the combined resolution proposed by the Reference Committee. The amendment proposed by MSS Delegates was adopted by the House.
HOD Action: Substitute resolution 608 was adopted as amended (see resolution 608 below).

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**ACTIONS ON ALL CONSIDERED REPORTS**

3. **BOT Report 1 – ANNUAL REPORT**

   MSS Action: MSS Delegates took no position on this report.
   
   HOD Action: BOT Report 1 was filed.
   
   The Consolidated Financial Statements for the years ended December 31, 2020 and 2019 and the Independent Auditor’s report have been included in a separate booklet, titled “2020 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

4. **BOT Report 2 (informational) – 2019 GRANTS AND DONATIONS**

   MSS Action: MSS Delegates took no position on this informational report.
   
   HOD Action: BOT Report 2 was filed.
   
   This informational financial report details all grants or donations received by the American Medical Association during 2020.

5. **BOT Report 3 – AMA 2022 DUES**

   MSS Action: MSS Delegates supported this report.
   
   HOD Action: The recommendations of BOT Report 3 were adopted and the remainder of the report was filed.
   
   Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA’s membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

   **RECOMMENDATION**

   2022 Membership Year

   The Board of Trustees recommends no change to the dues levels for 2022, that the following be adopted and that the remainder of this report be filed:

   - Regular Members $420
   - Physicians in their fourth year of practice $315
   - Physicians in their third year of practice $210
   - Physicians in their second year of practice $105
   - Physicians in their first year of practice $60
Physicians in military service          $ 280 
Semi-retired physicians               $ 210 
Fully retired physicians              $ 84  
Physicians in residency training      $ 45  
Medical students                      $ 20 

6. **BOT Report 4 (informational) – UPDATE ON CORPORATE RELATIONSHIPS**

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 4 was filed.

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2020. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT).

7. **BOT Report 5 (informational) – AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2020**

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 5 was filed.

Policy G-605.050, “Annual Reporting Responsibilities of the AMA Board of Trustees,” calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

8. **BOT Report 6 (informational) – ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2020 THROUGH FEBRUARY 2021**

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 6 was filed.

This report summarizes trends and news on tobacco usage, policy implications, and American Medical Association (AMA) tobacco control advocacy activities from March 2020 through February 2021. The report is written pursuant to AMA Policy D-490.983, “Annual Tobacco Report.”

9. **BOT Report 7 – COUNCIL ON LEGISLATION SUNSET REVIEW OF 2011 HOUSE POLICIES**

MSS Action: MSS Delegates supported this report.

HOD Action: BOT Report 7 was filed.

To view the policies being retained and the policies being rescinded, see the report at this link: [https://www.ama-assn.org/system/files/2021-06/j21-ceja-reports.pdf](https://www.ama-assn.org/system/files/2021-06/j21-ceja-reports.pdf)
Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and relevant.

10. BOT Report 8 (informational) – PLAN FOR CONTINUED PROGRESS TOWARD HEALTH EQUITY (CENTER FOR HEALTH EQUITY ANNUAL REPORT)

MSS Action: This report was extracted for amendment. MSS Delegates supported this report in its original form.

HOD Action: BOT Report 8 was filed.

This report is the second of its kind submitted for information to the House of Delegates, following Report 15 from the November 2020 Special Meeting. In June 2018, the House of Delegates adopted Policy D-180.981, “Plan for Continued Progress Toward Health Equity,” directing our AMA to develop “an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.” Since the 2019 establishment of our AMA Center for Health Equity (“the CHE”, “the Center”), our AMA continues to make advances in embedding equity in medicine and in public health. This report illustrates those internal activities and strategies, as well as alludes to external events of year 2020 through half of 2021, which deepened and hasten our AMA’s commitment to equity across what will assuredly be known as a fateful year in the nation and in the world.


MSS Action: MSS Delegates took no position on this report.

HOD Action: The recommendations of BOT Report 9 were adopted. Resolution 703-A-19 was not adopted. The remainder of the report was filed.

12. BOT Report 10 – PROTESTER PROTECTIONS (RESOLUTION 409-NOV-20)

MSS Action: MSS Delegates supported the recommendations of this report. Of note, 409-NOV-20 was authored originally by the MSS.

HOD Action: The recommendations of BOT Report 9 were adopted in lieu of resolution 409-NOV-20. The remainder of the report was filed.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 409, November 2020 Special Meeting, and the remainder of this report be filed.

Less-Lethal Weapons and Crowd Control

Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd
control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of nonviolent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm.

13. BOT Report 11 (informational) – REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 11 was filed.


MSS Action: MSS Delegates supported this report.

HOD Action: The recommendations of BOT Report 12 were adopted in lieu of resolution 606-NOV-20. The remainder of the report was filed.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following policy be adopted in lieu of Resolution 606-Nov-20 and the remainder of this report be filed:

Support for the Use of the Most Recent and Updated Edition of the *AMA Guides to the Evaluation of Permanent Impairment*.

Our American Medical Association supports the adoption of the most current edition of the *AMA Guides to the Evaluation of Permanent Impairment* by all jurisdictions to provide fair and consistent impairment evaluations for patients and claimants including injured workers.

15. BOT Report 13 – AMENDING THE AMA’S MEDICAL STAFF RIGHTS AND RESPONSIBILITIES (RESOLUTION 710-NOV-20)

MSS Action: MSS Delegates took no position on this report.
HOD Action: The recommendations of BOT Report 13 were adopted and the remainder of the report was filed.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 710-NOV-20 and that the remainder of the report be filed:

That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition and deletion:

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients’ best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization’s governing body.
b. The responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with
and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
   a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
   b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
   c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
   e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
   f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
   g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
   h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

16. BOT Report 14 – PHARMACEUTICAL ADVERTISING IN ELECTRONIC HEALTH RECORD SYSTEMS

MSS Action: MSS Delegates supported the recommendations of this report.

HOD Action: The recommendations of BOT Report 14 were adopted and the remainder of the report was filed.

RECOMMENDATIONS
The Board of Trustees recommends that Policy D-478.961 be amended as follows and the remainder of the report be filed:

Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical and promotional content in medical reference and e-prescribing software, unless such content complies with all provisions in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices (H-105.988); and (3) encourages the federal government to study of the effects of direct-to-physician prescriber advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, data privacy, health care costs, and EHR access for small physician practices; and (2) will study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. (4) opposes the preferential placement of brand name medications in e-prescription search results or listings; and (5) will encourage e-prescribing and EHR companies to ensure that the generic medication name will appear first in e-prescription search results and listings.

17. BOT Report 15 – REMOVING THE SEX DESIGNATION FROM THE PUBLIC PORTION OF THE BIRTH CERTIFICATE (RESOLUTION 5-I-19)

MSS Action: MSS Delegates supported the recommendations of this report. Of note, this report was written based upon a resolution originally authored by the MSS.

HOD Action: The recommendations of BOT Report 15 were adopted in lieu of resolution 5-I-19. The remainder of the report was filed.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-19 and the remainder of this report be filed.

Our American Medical Association will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual’s sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only.

18. BOT Report 16 – FOLLOW-UP ON ABNORMAL MEDICAL TEST FINDINGS (RESOLUTION 309-I-19)

MSS Action: MSS Delegates supported the recommendations of this report.

HOD Action: The recommendations of BOT Report 16 were adopted in lieu of resolution 309-I-19. The remainder of the report was filed.

RECOMMENDATIONS

The Board of Trustees recommends that the language below be adopted in lieu of Resolution 309-I-19 and the remainder of this report be filed.
Our American Medical Association encourages relevant national medical specialty societies to develop and disseminate evidence-based guidelines for communication and follow-up of abnormal and critical test results to promote better patient outcomes.

Our AMA will work with appropriate state and medical specialty societies to highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings to promote better patient outcomes.

Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care while ensuring appropriate privacy safeguards.


MSS Action: MSS Delegates supported the recommendations of the report.

HOD Action: The recommendations of BOT Report 17 were adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

That AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology retain representation in the American Medical Association House of Delegates.

20. BOT Report 18 – DIGITAL VACCINE CREDENTIAL SYSTEMS AND VACCINE MANDATES IN COVID-19

MSS Action: MSS Delegates supported the recommendations of this report.

HOD Action: The recommendations of BOT Report 18 were adopted in lieu of Resolution 230. An additional recommendation was referred for decision, and the remainder of the report was filed.

RECOMMENDATIONS
In light of the foregoing, the Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

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

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials
   a. vaccine is widely accessible;
   b. equity-centered privacy protections are in place to safeguard data collected from individuals;
   c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and
   d. credentials address the situation of individuals for whom vaccines are medically contraindicated.

2. Recommends that decisions to mandate COVID-19 vaccination be made only:
   a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
   b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
   c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
   d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.

3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust.

4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection.

Editor’s note. The following amendment to add a fifth recommendation was referred for decision:

Recommends that vaccine credentials are not used to prevent immigration, that vaccines be offered upon arrival that vaccination is required to be accepted prior to entry in the US, and that vaccine mandates are uniformly applied regardless of citizenship.

21. Speakers Report 1 (informational) – RECOMMENDATIONS FOR POLICY RECONCILIATION

MSS Action: MSS Delegates took no position on this informational report.
HOD Action: The reconciliations of Speakers Report 1 were accomplished, and the remainder of the report was filed.

Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” calls on your Speakers to “present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete.”

22. Speakers Report 2 – REPORT OF THE ELECTION TASK FORCE

MSS Action: MSS Delegates were advised to take no position on this report.

HOD Action: Recommendations 1–15, 17–31, 33, 34, and 36–41 were adopted. Recommendation 35 was adopted as follows. Recommendation 16 was referred. Recommendation 32 was not adopted. The remainder of the report was filed.


23. CCB Report 1 – BYLAW ACCURACY: SINGLE ACCREDITATION ENTITY FOR ALLOPATHIC AND OSTEOPATHIC GRADUATE MEDICAL EDUCATION PROGRAMS

MSS Action: MSS Delegates supported the report’s recommendations.

HOD Action: CCB Report 1 was adopted and the remainder of the report was filed.

During 2020, the five-year transition from dual accreditation entities acknowledged in the AMA Bylaws (ACGME for allopathic physicians and AOA for osteopathic physicians) to a single accreditation entity for all was completed. The ACGME now serves as the nation’s sole accreditor for both osteopathic (DO) and allopathic (MD) residencies and fellowships.

The Council has prepared this report with appropriate bylaw amendments to ensure that the AMA Constitution and Bylaws remains an accurate document.

RECOMMENDATIONS

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

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria: a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education of the American Osteopathic Association.
b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including undersea medical officers or flight surgeons) before their return to complete a residency.

c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

b) Members who are serving, as their primary occupation, in a structured educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

24. CCB Report 2 – AMA WOMEN PHYSICIANS SECTION: CLARIFICATION OF BYLAW LANGUAGE

MSS Action: MSS Delegates took no position on the report’s recommendations.

HOD Action: CCB Report 2 was referred.

In 2013, the Board of Trustees Women Physicians Advisory Committee transitioned to the Women Physicians Section (WPS). The Council has worked closely with the WPS since its inception and developed the existing bylaw language. The Council also has reviewed several iterations of the WPS Internal Operating Procedures that were approved by the Board in 2013 and in 2017.

The IOP states that "all female physician and medical student members of the AMA as identified in the AMA Masterfile are automatically enrolled in the WPS." The IOP further provides the opportunity for any other AMA member to opt-in as a WPS member. However, AMA Bylaw 7.10.1, states that "all female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section." Per Bylaw 7.10.11, "Other active AMA members who express an interest in women's issues shall be eligible for WPS membership." The subtle distinction is that according to the Bylaws, all AMA member female physicians and students are "eligible" to join, whereas the IOP includes them "automatically". The WPS Governing Council has asked the Council to consider proposing changes to Bylaw 7.10.1.

The WPS believes the IOP language better reflects the intent of the House when it created the section and supports the existing practice of automatically enrolling all AMA member female physicians as WPS members. The Council on Constitution and Bylaws concurs and presents this report for House action.

RECOMMENDATIONS
The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.
7.10.1 Membership. All female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section. 7.10.1.1 Other active members of the AMA who express an interest in women’s issues shall be eligible to join the section.

25. CCB Report 3 – CLARIFICATION TO BYLAW 7.5.2, CESSATION OF ELIGIBILITY (FOR THE YOUNG PHYSICIANS SECTION)

MSS Action: MSS Delegates took no explicit position on the report. However, MSS Delegates supported YPS’s proposed amendments and changes to the recommendations on the Report.

HOD Action: CCB Report 3 was adopted and the remainder of the report was filed.

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

7.5 Young Physician Section. The Young Physicians Section is a fixed Section.
7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.
7.5.2 Cessation of Eligibility of Governing Council Members. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If any officer’s or member’s term would terminate prior to the conclusion of an Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA. The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA.
7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past
chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.


MSS Action: MSS Delegates supported the report’s recommendations.

HOD Action: CCB Report 4 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Constitution and Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

6.5 Council on Ethical and Judicial Affairs.

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6.5.7 Term.

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6.5.7.2 Except as provided in Bylaw 6.5.7.2.1 and Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 3 2 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.

6.5.7.2.1 Any resident/fellow physician Council member who was elected at or prior to the 2021 June Meeting shall be elected for a term of 3 years. This provision shall automatically sunset when no longer applicable.

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.

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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 3 2-year term.

6.6 Council on Long Range Planning and Development.

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 3-2 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.

6.6.3.2.1 Any resident/fellow physician Council member who was appointed prior to the 2021 June Meeting shall be appointed for a term of 3 years. This provision shall automatically sunset when no longer applicable.

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 3 2-year term.


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 3 2 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.

6.9.1.2.1 Any resident/fellow physician Council member who was elected before or at the 2021 June Meeting shall be elected for a term of 3 years. This provision shall automatically sunset when no longer applicable.

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 3 2-year term.

27. CCB Report 5 – AMA BYLAWS – YPS ELIGIBILITY

MSS Action: MSS Delegates supported the YPS’s amendments to this report.
HOD Action:

CCB Report 5 was adopted and the remainder of the report was filed.

At the June 2021 Meeting, the House of Delegates adopted Substitute Resolution 24 from the Young Physicians Section in lieu of original Resolution 24. House action on Substitute Resolution 24 called for amendments to our AMA Bylaws to allow continued Governing Council service for those physicians elected to a leadership position, and further redefines Governing Council eligibility through the calendar year.

To implement Substitute Resolution 24, the Council has prepared appropriate amendments to the AMA Bylaws and presents them for consideration by the House of Delegates.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Constitution and Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section 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 last.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member’s term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting following that in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect through the end of the chair role, or 2nd year. The chair-elect, chair and immediate past chair shall be granted membership in the Section and be permitted to complete the term of office even if unable to continue to meet all of the requirements of
Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

28. CEJA Opinion 1 – AMENDMENT TO OPINION 1.2.2, “DISRUPTIVE BEHAVIOR AND DISCRIMINATION BY PATIENTS”

MSS Action: MSS Delegates took no position on the opinion.

HOD Action: CEJA Opinion 1 was filed.

E-1.2.2 – Disruptive Behavior and Discrimination by Patients

The relationship between patients and physicians is based on trust and should serve to promote patients’ wellbeing while respecting the dignity and rights of both patients and physicians.

Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those who are targeted.

(b) Always treat patients with compassion and respect.

(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient’s behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) Prioritize the goals of care when deciding whether to decline or accommodate a patient’s request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.

(e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests.

(f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.
(g) Terminate the patient-physician relationship only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient’s control, in keeping with ethics guidance.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

(i) Educate staff, patients, and the community about the institution’s expectations for behavior.

(j) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.

(l) Collect data regarding incidents of discrimination by patients and their effect on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community. (I, II, VI, IX)

29. CEJA Opinion 2 – AMENDMENT TO OPINION 8.7, “ROUTINE UNIVERSAL IMMUNIZATION OF PHYSICIANS”

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: CEJA Opinion 2 was filed.

E-8.7 – Routine Universal Immunization of Physicians

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues’ well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective
vaccine, physicians have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician’s patients.

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions’ responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact. (I, II)

30. CEJA Report 1 – CEJA’s Sunset Review of 2011 House Policies

MSS Action: MSS Delegates supported the Minority Affairs Section Delegates in requesting that policy H-460.924, Race and Ethnicity as Variables in Medical Research, not be rescinded.

HOD Action: H-460.924 was retained. The recommendations of CEJA Report 1 were adopted and the remainder of the report was filed.

To view the policies being retained and rescinded, see the report at this link: https://www.ama-assn.org/system/files/2021-06/j21-ceja-reports.pdf

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association policies to ensure that our AMA’s policy database is current, coherent, and relevant.

31. CEJA Report 2 – Short-term Medical Service Trips

MSS Action: MSS Delegates supported the referral of this report, citing concerns about language and about the lack of consideration of the history of colonization and its ongoing impacts.

HOD Action: CEJA Report 2 was referred.

RECOMMENDATIONS

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:
Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and vulnerable communities. The realities of scarcity and vulnerability define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.

(b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members bring appropriate skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers’ personal health needs as appropriate.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the “cultural sensitivity” they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally.
(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor’s country.

(f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor’s country.

32. CEJA Report 3 – AMENDMENT TO OPINION E-9.3.2, “PHYSICIAN RESPONSIBILITIES TO IMPAIRED COLLEAGUES”

MSS Action: MSS Delegates supported this report.

HOD Action: The recommendations of CEJA Report 3 were adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, “Physician Responsibilities to Impaired Colleagues,” be retitled as “Physician Responsibilities to Colleagues with Illness, Disability or Impairment” and amended by substitution as follows; and the remainder of this report be filed:

Providing safe, high quality care is fundamental to physicians’ fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians’ ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians’ relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no
longer endangering patients and that the individual receive appropriate
evaluation and care to treat any impairing conditions.
(d) Protect the interests of patients by promoting appropriate interventions when
a colleague continues to provide unsafe care despite efforts to dissuade them
from practice.
(e) Seek assistance when intervening, in keeping with institutional policies,
regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional
culture by:

(f) Encouraging the development of practice environments that promote collegial
mutual support in the interest of patient safety.
(g) Encouraging development of inclusive training standards that enable
individuals with disabilities to enter the profession and have safe, successful
careers.
(h) Eliminating stigma within the profession regarding illness and disability.
(i) Advocating for supportive services and accommodations to enable physicians
who require assistance to provide safe, effective care.
(j) Advocating for respectful and supportive, evidence-based peer review policies
and practices that will ensure patient safety and practice competency.

33. CEJA Report 4 (informational) – Augmented Intelligence & the Ethics of Innovation in
   Medicine

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: CEJA Report 4 was filed.

34. CEJA Report 5 – Judicial Function of the Council on Ethical and Judicial Affairs – Annual
   Report

MSS Action: MSS Delegates took no position on this report.

HOD Action: CEJA Report 5 was filed.

Beginning with the 2003 report, the Council has provided an annual tabulation of
its judicial activities to the House of Delegates. In the appendix to this report, a
tabulation of CEJA’s activities during the most recent reporting period is
presented.

35. CLRDP Report 1 (informational) – DEMOGRAPHIC CHARACTERISTICS OF THE HOUSE OF
    DELEGATES AND AMA LEADERSHIP

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: CLRDP Report 1 was filed.

36. CME Report 1 – COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2011 HOUSE
   POLICIES

MSS Action: MSS Delegates supported this report.
HOD Action: CME Report 1 was adopted and the remainder of the report was filed.

To view the policies that were either retained or rescinded in this report, please download the report at this link: https://www.ama-assn.org/system/files/2021-06/j21-clrpd-reports.pdf

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association policies to ensure that our AMA’s policy database is current, coherent, and relevant.

37. CME Report 2 – LICENSURE FOR INTERNATIONAL MEDICAL GRADUATES PRACTICING IN U.S. INSTITUTIONS WITH RESTRICTED MEDICAL LICENSES (RESOLUTION 311-A-19)

MSS Action: MSS Delegates could find no MSS policy on this topic but considered taking a stance. Ultimately, the Caucus voted to take no position.

HOD Action: CME Report 2 was adopted and the remainder of the report was filed.

SUMMARY AND RECOMMENDATIONS

Existing AMA policy is of two minds in terms of the requirements for full licensure and board certification. Indeed, the need for an expanded workforce, to meet the growing needs of patients for access to health care services, must be balanced with requisite caution in awarding licensure for practice, given the need to protect the public and ensure the quality of the medical workforce. Given, however, that physicians who have been serving their communities for years may have their careers jeopardized as a result of employers adopting new employment standards, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 311-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification.

2. That our AMA amend Policy H-255.988 (12), “AMA Principles on International Medical Graduates,” by addition to read as follows: Our AMA supports …12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community.
3. That our AMA amend Policy H-275.934 (2), “Alternatives to the Federation of State Medical Boards Recommendations on Licensure,” by addition to read as follows:

2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community.

4. That our AMA amend Policy H-160.949 (6), “Practicing Medicine by Non-Physicians,” by addition and deletion to read as follows:

Our AMA … (6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education in the U.S).

5. That our AMA amend Policy H-275.978 (5), “Medical Licensure,” by addition to read as follows:

Our AMA … (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for “assistant physicians.” It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

38. CME Report 3 – OPTIMIZING MATCH OUTCOMES (RESOLUTION 304-I-19)

MSS Action: MSS Delegates supported this report.

HOD Action: CME Report 3 was adopted and the remainder of the report was filed.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 304-I-19 and the remainder of this report be filed:


2. That our AMA encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
39. CME Report 4 – EXPEDITING ENTRY OF QUALIFIED IMG PHYSICIANS TO U.S. MEDICAL PRACTICE (RESOLUTION 308-I-19)

MSS Action: MSS Delegates supported this report.

HOD Action: CME Report 4 was adopted and the remainder of the report was filed.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That American Medical Association (AMA) Policy D-255.980 (1), “Impact of Immigration Barriers on the Nation’s Health,” that reads, “Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine” be reaffirmed.

2. That our AMA encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas.

3. That our AMA encourage the Federation of State Medical Boards and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation.

4. That Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to US Medical Practice,” be rescinded, as having been fulfilled by this report.

40. CME Report 5 – PROMISING PRACTICES AMONG PATHWAY PROGRAMS TO INCREASE DIVERSITY IN MEDICINE

MSS Action: MSS Delegates supported this report.

HOD Action: CME Report 5 was adopted and the remainder of the report was filed.

The Council on Medical Education recommends the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.

2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity.

3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
4. That our AMA work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.

5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce, by addition and deletion to read as follows:

   Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality—persons with disabilities; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this and strategies to accomplish that goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights, by addition to read as follows:

   Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that 1) decrease the educational opportunity gap; 2) increase participation in high school Advanced Placement courses; and 3) increase the high school graduation rate.

7. That our AMA amend Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,” by deletion to read as follows:

   (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and

9. That our AMA advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.

10. That our AMA work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

11. That our AMA establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

41. CMS Report 1 – COUNCIL ON MEDICAL SERVICE’S SUNSET REVIEW OF 2011 HOUSE POLICIES

MSS Action: MSS Delegates supported this report.

HOD Action: CMS Report 1 was adopted and the remainder of the report was filed.

To view the policies that were either retained or rescinded in this report, please download the report at this link: https://www.ama-assn.org/system/files/j21-cms-reports.pdf

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association policies to ensure that our AMA’s policy database is current, coherent, and relevant.

42. CMS Report 2 – CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM HOSPITAL SETTINGS (RESOLUTION 212-A-19, SECOND RESOLVE)

MSS Action: MSS Delegates supported the recommendations of this report.

HOD Action: The recommendations of CMS Report 2 were adopted in lieu of the second Resolved of 212-A-19 and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge.

2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s
health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge.

3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients.

4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors.

5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals.

6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools.

7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers.

8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work to resolve them.

9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication.

43. CMS Report 3 – UNIVERSAL BASIC INCOME PILOT STUDIES (RESOLUTION 236-A-19)

MSS Action: MSS Delegates supported the spirit of this report as it stemmed from a resolution that was originally introduced by the MSS. We asked that this report be amended to reflect our original resolution better and this amendment was adopted as the final recommendation.

HOD Action: CMS Report 3 was adopted and the remainder of the report was filed.

RECOMMENDATIONS
The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization.
2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation’s most vulnerable populations.
3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act.
4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.
5. That our AMA reaffirm Policy H-290.997 stating that greater equity in the Medicaid program should be achieved through the creation of adequate payment levels to ensure broad access to care.
6. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care.
7. That our AMA encourage Universal Basic Income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs.

44. CMS Report 4 – PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION

MSS Action: MSS Delegates supported this report.

HOD Action: CMS Report 4 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized.
3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions.
4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans’ coverage decisions and policies.

5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services.

6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.

7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.

8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.

9. That our AMA continue to advocate for a reduction in the overall volume of health plans’ PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.

10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein.

11. That our AMA advocate that health plans must undertake every effort to accommodate the physician’s schedule when requiring peer-to-peer prior authorization conversations.

12. That our AMA advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

45. CMS Report 5 – MEDICAL CENTER PATIENT TRANSFER POLICIES (RESOLUTION 818-I-19)

MSS Action: MSS Delegates took no position on this report.

HOD Action: CMS Report 5 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:

   H-130.982 Interfacility Patient Transfers of Emergency Patients

   Our AMA: (1) supports the following principles for the interfacility patient transfers of emergency patients: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide
needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician’s judgment it is in the patient’s best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to physician organizations that are their county medical societies as they developing such protocols and interhospital agreements with their local hospitals.

2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows:
   d. The right to be well informed and share in the decision-making of the health care organization’s operational and strategic planning, including involvement in decisions to grant exclusive contracts, or close medical staff departments, or to transfer patients into, out of, or within the health care organization.

3. That our AMA amend Policy H-130.965 by addition as follows:
   Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred.

4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:
   4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff.
6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities.


46. CMS Report 6 – URGENT CARE CENTERS

MSS Action: MSS Delegates took no position on this report.

HOD Action: CMS Report 6 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team.
3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient’s primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists.
4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services.
5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
   a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;
   b. UCCs must transfer a patient’s medical records to his or her primary care physician and to other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;
   c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
   d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
   e. UCCs should use local physicians as medical directors or supervisors, and they should be clearly identified and posted;
   f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being
rendered, describe the degree of physician supervision of any non-
physician practitioners, and include in any marketing materials the
qualifications of the on-site health care providers; and
g. UCCs should be prohibited from using the word “emergency” or “ED”
in their name, any of their advertisements, or to describe the type of care
provided.

6. That our AMA work with interested stakeholders to improve attribution
methods such that a physician is not attributed to spending for services that a
patient receives at an UCC if the physician could not reasonably control or
influence that spending.

7. That our AMA support patient education including notifying patients if their
physicians are providing extended hours care, including weekends, informing
patients what to do in urgent situations when their physician may be unavailable,
informing patients of the differences between an urgent care center and an
emergency department, asking for their patients to notify their physician or usual
source of care before seeking UCC services, and encourage patients to
familiarize themselves with their anticipated out-of-pocket financial responsibility
for UCC services.

47. CMS Report 7 – ADDRESSING EQUITY IN TELEHEALTH (RESOLVE 2, ITEMS A AND C OF
ALTERNATE RESOLUTION 203-NOV-20)

MSS Action: MSS Delegates supported this report.

HOD Action: CMS Report 7 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in
lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and
that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963,
which advocates for equitable access to telehealth services, especially for at-risk
and under-resourced patient populations and communities, including but not
limited to supporting increased funding and planning for telehealth infrastructure
such as broadband and internet-connected devices for both physician practices
and patients.

2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion
of broadband and wireless connectivity to all rural and underserved areas of the
United States.

3. That our AMA encourage initiatives to measure and strengthen digital literacy,
with an emphasis on programs designed with and for historically marginalized
and minoritized populations.

4. That our AMA encourage telehealth solution and service providers to
implement design functionality, content, user interface, and service access best
practices with and for historically minoritized and marginalized communities,
including addressing culture, language, technology accessibility, and digital
literacy within these populations.
5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities.

6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.

7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

8. That our AMA support expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.

9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth.

11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient’s current physicians.

12. That our AMA advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

13. That our AMA recognize access to broadband internet as a social determinant of health.

48. CMS Report 8 – LICENSURE AND TELEHEALTH (RESOLVE 2, ITEMS B AND D OF ALTERNATE RESOLUTION 203-NOV-20)

MSS Action: MSS Delegates took no position on this report.

HOD Action: Recommendation 1 of CMS Report 8 was referred for decision, while recommendations 2-5 were adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.

[Editor’s note: Recommendation 1 referred for decision.]
1. That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:
   a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
   b) There is a pre-existing and ongoing physician-patient relationship.
   c) The physician has had an in-person visit(s) with the patient.
   d) The telehealth services are incident to an existing care plan or one that is being modified.
   e) The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed.
   f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

[Editor’s note: Recommendations 2 to 5 adopted.]

2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:

   The Promotion of Quality Telemedicine H-480.969

   (1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
   (a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board’s state;
   (ba) exemption from such a licensure requirement for traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation;
   (eb) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
   (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
   (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

3. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946, Coverage and Payment for Telemedicine.
4. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.

5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state’s medical board.

49. CMS Report 9 – ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS

MSS Action: MSS Delegates supported this report.

HOD Action: CMS Report 9 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act.

2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates.

3. That our AMA advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
   a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
   b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
   c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
   d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
   e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
   f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.

4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
5. That our AMA support better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

6. That our AMA encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

50. CSAPH Report 1 – COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF 2011 HOUSE POLICIES

MSS Action: MSS Delegates supported this report.

HOD Action: CSAPH Report 1 was adopted and the remainder of the report was filed.

To view the policies that were either retained or rescinded in this report, please download the report at this link: https://www.ama-assn.org/system/files/j21-csaph-reports.pdf

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association policies to ensure that our AMA’s policy database is current, coherent, and relevant.

51. CSAPH Report 2 – USE OF DRUGS TO CHEMICALLY RESTRAIN AGITATED INDIVIDUALS OUTSIDE OF HOSPITAL SETTINGS

MSS Action: MSS Delegates supported this report and the amendments that were offered to it by the reference committee.

HOD Action: CSAPH Report 2 was adopted and the remainder of the report was filed.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:

1. That the following new AMA policy be adopted:
   Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting

   Our American Medical Association:
   1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;
   2. Recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction;
   3. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high
mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers;
4. Opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and not for a legitimate medical reason;
5. Recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;
6. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
   a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
   b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
   c. Assess that comprehensive training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:
      i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting;
      ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications;
      iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers
   d. Ensure that appropriate financial support by local and/or state agencies for training and reporting is available; and
   e. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training;
7. Urges law enforcement and frontline emergency medical service personnel, who are a part of the “dual response” in emergency situations, to participate in appropriate training overseen by EMS medical directors. The training should minimally include de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting; and
8. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental
health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way.

2. That Policy H-65.954, “Policing Reform,” which recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA’s willingness to work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers, states that AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures, and will advocate for legislation and regulations which promote trauma-informed, community-based safety practices, be reaffirmed.

3. That Policy H-345.972, “Mental Health Crisis Interventions,” which supports jail diversion and community based treatment options for mental illness, implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, federal funding to encourage increased community and law enforcement participation in crisis intervention training programs, and legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities, be reaffirmed.

52. CSAPH Report 3 – ADDRESSING INCREASES IN YOUTH SUICIDE

MSS Action: MSS Delegates offered an amendment to add the third resolved clause to section two of these recommendations. This amendment was accepted and your MSS Delegates supported the adoption of this report as amended.

HOD Action: The final recommendation of this report was referred for decision. The remainder of CSAPH Report 3 was adopted and the report was filed.

RECOMMENDATIONS
The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That Policy H-60.937 be amended to read as follows:

Teen Youth and Young Adult Suicide in the United States

Our AMA:

(1) Recognizes teen youth and young adult suicide as a serious health concern in the US;

(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and
acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;

(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;

(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;

(5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations and among youth and young adults with disabilities;

(6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;

(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;

(8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;

(9) That our AMA advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health; and

(10) That our AMA advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents.

2. That Policy H-515-952, “Adverse Childhood Experiences and Trauma-Informed Care” be amended by addition to read as follows:

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:
   a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

3. That Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” which recognizes the role of firearms in suicides; encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling; and encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide, be reaffirmed.

4. That Policy H-170.984, “Healthy Living Behaviors,” encouraging state medical societies and physicians to promote physical and wellness activities for children and youth and to advocate for health and wellness programs for children and youth in schools and communities, be reaffirmed.

That our AMA consider supporting the Child and Adolescent Mental and Behavioral Health Principles 2021 developed by the American Academy of Pediatrics and partner organizations including AACAP, APA and Children’s Hospital Association among others, and join with these and other partner organizations in advocating for a comprehensive approach to the child and adolescent mental and behavioral health crisis.

Editor’s note: The following proposed addition to Policy H-60.937 (as paragraph 11) was referred for decision:

That our AMA consider supporting the Child and Adolescent Mental and Behavioral Health Principles 2021 developed by the American Academy of Pediatrics and partner organizations including AACAP, APA and Children’s Hospital Association among others, and join with these and other partner organizations in advocating for a comprehensive approach to the child and adolescent mental and behavioral health crisis.

53. CCB and CLRPD Report 1 – JOINT COUNCIL SUNSET REVIEW OF 2011 HOUSE POLICIES

MSS Action: MSS Delegates took no position on this report.
HOD Action: CCB and CLRPD Report 1 was adopted and the remainder of the report was filed.

To view the policies that were either retained or rescinded in this report, please download the report at this link: https://www.ama-assn.org/system/files/2021-06/j21-joint-reports.pdf

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association policies to ensure that our AMA’s policy database is current, coherent, and relevant.

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**ACTIONS ON ALL OTHER RESOLUTIONS**

1. **Res. 001 – Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD)**

   MSS Action: MSS Delegates could not find direct MSS policy on this resolution but your MSS Caucus voted to support it.

   HOD Action: Resolution 001 was adopted with a title change as follows:

   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.

2. **Res. 003 - Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions**
MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 003 was adopted as follows:

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

Healthcare 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.

3. Res. 004 - AMA Resident/Fellow Councilor Term Limits

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 004 was adopted as follows:

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.

4. **Res. 006 - Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients**

   **MSS Action:** MSS Delegates supported the resolution.

   **HOD Action:** Resolution 006 was adopted as follows:

   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.”

5. **Res. 007 - Nonconsensual Audio/Video Recording at Medical Encounters**

   **MSS Action:** MSS Delegates took no position on the resolution.

   **HOD Action:** Resolution 007 was 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.

6. **Res. 009 - Supporting Women and Underrepresented Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties**

   **MSS Action:** MSS Delegates supported the resolution.

   **HOD Action:** Resolution 009 was adopted as follows:

   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.

7. Res. 022 - Maternal Levels of Care Standards of Practice
   MSS Action: MSS Delegates supported the resolution.
   HOD Action: Policy H-245.971 was reaffirmed in lieu of Resolution 022

8. Res. 023 - Pandemic Ethics and the Duty of Care
   MSS Action: MSS Delegates supported the resolution.
   HOD Action: Resolution 023 was adopted as follows:

   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.

9. Res. 024 - AMA Bylaws Language on AMA Young Physicians Section Governing Council Eligibility
   MSS Action: MSS Delegates supported the resolution. Subsequently, YPS Delegates introduced amended language, which MSS Delegates also supported.
   HOD Action: Resolution 024 was 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.

10. Res. 105 - Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 105 was referred for decision.

11. Res. 121 - Medicaid Dialysis Policy for Undocumented Patients

MSS Action: MSS Delegates offered an amendment on the resolution, so that scheduled outpatient dialysis would be covered and Emergency Medicaid would be included, and supported it as amended.

HOD Action: The MSS amendment was supported in the Reference Committee and adopted by the House. Resolution 121 was adopted as follows:

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.

12. Res. 122 - Developing Best Practices for Prospective Payment Models

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 122 was referred.


MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The following alternate resolution was adopted in lieu of Resolution 201.

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.

14. Res. 206 - Redefining the Definition of Harm

MSS Action: MSS Delegates found no direct MSS policy on this topic but the MSS Caucus voted to support it.
HOD Action: Resolution 206 was considered with Resolution 212 and the following was adopted in lieu of Resolution 212.

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 clinician 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.

15. Res. 210 - Ransomware and Electronic Health Records

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 210 was adopted as follows:

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.

16. Res. 212 - ONC’s Information Blocking Regulations

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 212 was considered with Resolution 206 and the following was adopted in lieu of Resolution 212:

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 clinician 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.

17. Res. 213 - CMMI Payment Reform Models

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 213 was adopted as follows:

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.

18. Res. 226 - Interest-Based Debt Burden on Medical Students and Residents
MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 226 was adopted as follows:

RESOLVED, That our American Medical Association strongly advocate for the passage of legislation to allow medical students, residents, and fellows who have 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.

19. Res. 227 - Audio-Only Telehealth for Risk Adjusted Payment Models

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 227 was adopted as follows:

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.

20. Res. 228 - COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 228 was adopted as follows:

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


21. Res. 232 - Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 232 was adopted as follows:

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.

22. Res. 233 - Non-Physician Title Misappropriation

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 233 was adopted as follows:

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.

23. Res. 304 - Decreasing Financial Burdens on Residents and Fellows

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 304 was adopted as follows with the final resolved clause being referred.

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

24. Res. 305 - Non-Physician Post-Graduate Medical Training

MSS Action: MSS has no direct policy on this resolution but voted to support the resolution.

HOD Action: Resolution 305 was adopted as follows with the final two resolved clauses being referred.

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 allows 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.

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.

25. Res. 308 - Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure

MSS Action: MSS Delegates supported the resolution.

HOD Action: The following alternate resolution was adopted in lieu of Resolution 308:

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

26. Res. 309 - Supporting GME Program Child Care Residency Training

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 309 was adopted as follows with a title change:

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).

27. Res. 310 - Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 310 was adopted as follows with a title change:

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.

28. Res. 311 - Student Loan Forgiveness

MSS Action: MSS Delegates supported the resolution.

HOD Action: The following alternate resolution was adopted in lieu of Resolution 311.

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

29. Res. 318 - The Impact of Private Equity on Medical Training

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 318 was adopted as follows:

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.

30. Res. 319 - The Effect of the COVID-19 Pandemic on Graduate Medical Education

MSS Action: MSS Delegates noted this may be relevant to medical students since the next step for us is usually graduate medical education, but ultimately, given our lack of direct policy related to the asks, Delegates chose to take no position on the resolution.

HOD Action: Resolution 319 was adopted as follows:

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.

31. Res. 401 - Universal Access for Essential Public Health Services

MSS Action: MSS Delegates had concerns about the feasibility of the asks of this resolution but ultimately supported the resolution.

HOD Action: The first resolved clause of Resolution 401 was referred for report at the 2021 Interim meeting, while the second was referred for report at a later time.
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.

32. Res. 402 - Modernization and Standardization of Public Health Surveillance Systems

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: The following alternate resolution was adopted in lieu of Resolution 402:

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


33. Res. 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

MSS Action: MSS Delegates supported the spirit of this resolution but believed it was likely reaffirmation, and thus Delegates took no position on the resolution.

HOD Action: Resolution 403 was 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.

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 406 was adopted as follows with a title change:

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.

35. Res. 407 - Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 407 was adopted as follows:

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.

36. Res. 410 - Ensuring Adequate Health Care Resources to Address the Long COVID Crisis

MSS Action: MSS Delegates supported the resolution.

HOD Action: The following alternate resolution was adopted in lieu of Resolutions 410 and 413:

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 sequelae 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 sequelae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face.

37. Res. 411 - Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 411 was adopted as follows with a title change:

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.

38. Res. 420 - Impact of Social Networking Services on the Health of Adolescents

MSS Action: MSS Delegates supported the resolution.

HOD Action: The following alternate resolution was adopted in lieu of Resolution 420:

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.

39. Res. 503 - Access to Evidence-Based Addiction Treatment in Correctional Facilities
MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 503 was adopted as follows:

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. 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. 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. 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 abuse 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.

40. Res. 601 - $100 Member Annual Dues Payment Through 2023

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 601 was 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.

41. Res. 602 - Timely Promotion and Assistance in Advance Care Planning and Advance Directives

MSS Action: MSS Delegates supported the spirit of the resolution but also believed it was likely reaffirmation, and thus took no position on the resolution.

HOD Action: Resolution 602 was adopted as follows:

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.

42. Res. 608 - Sharing Covid-19 Resources

MSS Action: MSS Delegates submitted an amendment to add the fourth resolved clause and supported the resolution.

HOD Action: The following resolution was adopted in lieu of resolutions 608, 609, 610, and 611:

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.

43. Res. 609 - COVID-19 Crisis in Asia

MSS Action: MSS Delegates

HOD Action: Resolution 609 was considered with Resolutions 608, 609 and 610. See Resolution 608.

44. Res. 610 - Promoting Equity in Global Vaccine Distribution

MSS Action: MSS Delegates
HOD Action: Resolution 610 was considered with Resolutions 608, 609 and 610. See Resolution 608.

45. Res. 611 - COVID-19 Crisis in India

MSS Action: MSS Delegates supported the resolution.

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

46. Res. 702 - Addressing Inflammatory and Untruthful Online Ratings

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 702 was 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.

47. Res. 706 - Prevent Medicare Advantage Plans from Limiting Care

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 706 was adopted as follows:

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.

48. Res. 707 - Financial Incentives for Patients to Switch Treatments

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 707 was adopted as follows:

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

49. Res. 711 - Opposition to Elimination of “Incident-to” Billing for Non-Physician Practitioners

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 711 was adopted as follows:
RESOLVED, That our American Medical Association advocate against efforts to eliminate “incident-to” billing for non-physician practitioners among private and public payors.

50. Late 1002 - Prohibition of Racist Characterization Based on Personal Attributes

MSS Action: MSS Delegates supported extraction and non-consideration of this item.

HOD Action: This late resolution was extracted from the Report of the Rules and Credentials Committee. The House voted to not consider it.
RESOLVED, That it is the policy of our American Medical Association that no person or group of persons shall be considered characterized as racist based on personal attributes of race, color religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age disability, or genetic information.

51. Late 1003 - Free Speech and Civil Discourse in our American Medical Association

MSS Action: MSS Delegates supported extraction and non-consideration of this item.

HOD Action: This late resolution was extracted from the Report of the Rules and Credentials Committee. The House voted to not consider it.
RESOLVED, That it be the policy of our American Medical Association that:

Our American Medical Association unequivocally commits to truly open discourse, debate, exchange of ideas, and argument;

Our American Medical Association unequivocally commits to a culture which recognizes the inherent dignity and worth of its members, which resolves that freedom of expression and civility must coexist, and where those who disagree will do so without enmity;

Our American Medical Association unequivocally commits to the principle that dissenting and unpopular voices must be afforded the opportunity to be heard;

Our American Medical Association unequivocally commits that members of the American Medical Association of different faiths, philosophies, and persuasions may speak their minds and honor their deepest convictions without fear of punishment or retaliation;
Our American Medical Association unequivocally commits that the mere exposure to ideas that some may find offensive is not an act of violence or hatred;

Our American Medical Association unequivocally commits to a prohibition of the listing of people or organizations to be regarded as unacceptable, untrustworthy, excluded, or avoided based on ideological positions or differences;

Our American Medical Association unequivocally commits that ideological demonization of opponents to block debate and to silence disagreement in the proceedings of the American Medical Association is unprofessional conduct subject to appropriate disciplinary action;

Our American Medical Association unequivocally commits that defamation, obscenity, intimidation, threats, and incitement to violence, have no place in the proceedings of the American Medical Association, and if exhibited are unprofessional conduct subject to appropriate disciplinary action.


As stated earlier in the report, your MSS Delegates attempted to extract Resolutions 013, 014, 116, 317, 605, and 606 for consideration as House Business. The House of Delegates ultimately voted to adopt the recommendations of the Resolution Committee to not consider these items at the June 2021 Meeting.