**AMA-MSS Digest of Actions**

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5.000MSS Abortion

5.001MSS Public Funding of Abortion Services: AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16) (Reaffirmed: MSS Res 059, A-21)


5.005MSS MSS Stance on Challenges to Women’s Right to Reproductive Health Care Access: AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician’s ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A-16) (Reaffirmed: MSS Res 059, A-21)

5.006MSS Transparency on Restrictions of Care: AMA-MSS (1) supports advocating that all medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution’s willingness to perform the aforementioned services; (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient; and (3) supports advocating that all facilities and hospitals disclose all restrictions in care at their facility, and all physicians seeking employment at their facility. (MSS Res 13, A-17) (Amended: MSS Res 125, Nov. 2020)

5.007MSS Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone: AMA-MSS will ask the AMA to support efforts urging the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone. (MSS Res 14-I-17)
5.008MSS Expanding AMA Support for Advanced Practice Providers who Provide First-Trimester Abortion Care: AMA-MSS supports state and federal legislation that allows appropriately trained and credentialed advanced practice clinicians to perform first trimester medical and aspiration abortions in accordance with individual state licensing requirements. (MSS Res. 08, I-19)

5.009MSS Protecting Access to Abortion and Reproductive Healthcare: AMA-MSS will ask (1) that our AMA amends policy H-100.948, “Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex),” by addition and deletion as follows:

**Supporting Access to Mifepristone (Mifeprex), H-100.948**

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies.

And (2) that our AMA amends policy H-5.980, “Oppose the Criminalization of Self-Induced Abortion,” by addition and deletion as follows:

**Oppose the Criminalization of Abortion, H-5.980**

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment.

(MSS Res. 018, A-22) (Immediately forwarded, AMA Res. 027, Adopt as Amended [H-100.948, H-5.980], A-22)

10.000MSS Accident Prevention


10.003MSS Mandatory Labeling for Waterbeds and Beanbag Furniture: AMA-MSS will ask the AMA to encourage waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and distribute warning materials on each waterbed and other furnishings concerning the risks of leaving an infant or handicapped child who lacks the ability to roll over unattended on a waterbed or beanbag furniture. (AMA Amended Res 414, A-92 Adopted [H-245.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
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10.006MSS  In-Line Skating Injuries: AMA-MSS will ask the AMA to: (1) strongly recommend that all in-line skaters wear protective helmets, wrist guards, and elbow and knee pads, and support efforts to educate adults and children about in-line skating safety; and (2) encourage the availability of all safety equipment at the point of in-line skate purchase or rental. (AMA Sub Res 403, A-95, Adopted [H-10.975]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-10.975 Rescinded: CCB/CLRDP Rep. 1, A-14) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

10.008MSS  Promoting the Universal Use of Bicycle Helmets: AMA-MSS encourages sections to take advantage of current funding sources for community service initiatives to promote bicycle helmet use and to conduct events in their communities on safety education for all ages. (MSS Amended Res 12, A-09) (Reaffirmed: MSS GC Rep A, I-14) (Amended and Reaffirmed: MSS GC Rep A, I-19)

10.009MSS  Use of Protective Eyewear by Young Athletes: AMA-MSS will ask the AMA to establish policy in support of the use of protective eyewear for athletes who have had eye surgery or trauma, or are functionally one-eyed individuals, and for all other athletes engaged in high eye-risk sports. (MSS Sub Res 15, A-98) (AMA Amended Res 404, I-98, Adopted [H-10.970]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Amended and Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

10.010MSS  Return to Play After Suspected Concussion: AMA-MSS will ask the AMA to support the prohibition of athletes under age 18, who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, from returning to play or practice without a licensed health care provider's written approval. (MSS Res 24, A-10) (AMA Substitute Res 910, I-10 Adopted [H-470.959]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

10.011MSS  Skiing and Snowboarding Helmets and Safety: AMA-MSS will ask the AMA to (1) actively support skiing and snowboarding helmet use and encourage physicians to educate their patients about the importance of skiing and snowboarding helmet use; (2) encourage the manufacture, distribution, and utilization of safe, effective, and reasonably priced skiing and snowboarding helmets; (3) encourage the availability of helmets at the point of skiing and snowboarding purchase; and (4) develop model state/local legislation requiring the use of skiing and snowboarding safety helmets in the pediatric population, and calling for all who rent skis and snowboards to the pediatric population to offer the rental of skiing and snowboarding safety helmets. (MSS Res 25, A-10) (AMA Substitute Res 911, I-10 Adopted [H-470.974]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
10.012MSS  
**Helmet Safety:** AMA-MSS will ask the AMA to amend H-470.974 by insertion and deletion as follows:

H-470.974 Athletic Helmets

Our AMA urges the Consumer Product Safety Commission to establish standards that athletic and recreational helmets, including but not limited to football, baseball, hockey, horseback riding, bicycle and motorcycle riding, lacrosse, and skiing, produced or sold in the United States provide protection against head injury; and that the AMA advocate the use of appropriate and safe clear face guards as a permanent installation on the current bilateral ear protective batter's helmet to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5 to 14 18 years of age; that the AMA encourage the use of protective helmets and face shields to be worn by all baseball and softball pitchers in organized leagues from 5 to 18 years of age. 2. Our AMA: (a) supports legislation requiring the use of helmets by children ages 17 and younger while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing, or and snowboarding; (b) encourages the use of helmets in adults while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing or and snowboarding; (c) encourages physicians to educate their patients about the importance of helmet use while engaged in potentially dangerous athletic activities, including but not limited to sledding, skiing and snowboarding; and (d) encourages the availability of rental helmets at all commercial sledding, skiing and snowboarding areas.


10.013MSS  
**Implementing Bike Lanes to Improve Overall Bicyclist Safety:** AMA-MSS supports research on the safety and efficacy of the implementation of various forms of bicycle lanes in reducing crash incidence and severity. (MSS Res 39, I-13) (Reaffirmed: MSS GC Rep A, I-19)

10.014MSS  
**Improving the Safety of Playgrounds through Height Restrictions:** AMA-MSS supports the adoption of height restrictions and minimum protective surfacing requirements for playground equipment. (MSS Res 11, A-14) (Reaffirmed: MSS GC Rep A, I-19)

15.000MSS  
**Accident Prevention: Motor Vehicles**

15.001MSS  
**State Motorcycle Helmet Laws:** AMA-MSS will ask the AMA to: (1) endorse the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urge constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (3) join, when requested, with constituent societies to support the enactment or preservation of state motorcycle helmet laws. (AMA Res 77, I-80, Adopted [H-15.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-15.994 Rescinded: CCB/CLRPD Rep. 3, A-14) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

15.003MSS  


Seat Belt Compliance in Emergency Vehicle Patient Compartments: AMA-MSS will ask the AMA to collaborate with national emergency medicine and emergency medical services organizations to develop educational resources and training for employees regarding seat belt usage in the patient compartments of emergency vehicles; and (2) support the amendment of state seat belt laws with blanket exemptions for emergency medical services personnel such that these laws provide exemptions only when actively involved in patient care. (MSS Res 22, A-10) (AMA Amended Res 909, I-10, Adopted [H-15.982]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Report B, A-21)

Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs: AMA-MSS supports more comprehensive Graduated Driver Licensing programs including but not limited to more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions. (MSS Res 32, A-18)

Acquired Immunodeficiency Syndrome (AIDS)

AIDS Education: AMA-MSS: (1) encourages public school instruction, appropriate for a student's age and grade, on the nature of HIV and the prevention of its transmission starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a basic knowledge of the nature of HIV, the prevention of its transmission, the availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils. (MSS Sub Res 4, A-87) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed MSS GC Report A, I-17)

HIV Drug Availability: AMA-MSS will ask the AMA, as set forth in its objective of contributing to the betterment of the public health, to: (1) use its resources in cooperation with other health care organizations and agencies to facilitate the distribution of information on drug therapy availability for HIV/AIDS; and (2) encourage the FDA to continue to expedite the evaluation of available drugs used in the treatment of HIV/AIDS (AMA Res 177, A-88 Adopted as Amended [H-20.922]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)


20.012MSS  Policy Regarding HIV Infected Medical Students: AMA-MSS will ask the AMA to take the stand that a medical student who becomes infected with human immunodeficiency virus (HIV) and other blood-borne infectious diseases should not be prevented from completing his or her course of study and receiving their MD/DO degree based solely on their HIV seropositivity. (AMA Amended Res 413, I-92 Adopted [H-295.937]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (H-295.937 Rescinded, CME Rep. 2, A-13) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: GC Report A, I-21)


HIV Positive Immigration and Permanent Residency in the U.S.: AMA-MSS will ask the AMA to amend H-20.901 by insertion and deletion as follows:

H-20.901 HIV, Immigration, and Travel Restrictions

Our AMA: (1) Supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649); (2) Recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) Recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) Recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.


Modernization of HIV Specific Criminal Laws: AMA-MSS will ask the AMA to amend policy H-20.914 via insertion and deletion as follows:

H-20.914 Discrimination and Criminalization Based on HIV Seropositivity Our AMA: (1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; and (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; and (5) Supports consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.


20.021MSS Support Offering HIV Post Exposure Prophylaxis to All Survivors of Sexual Assault: AMA-MSS will ask the AMA to (1) advocate for education of physicians about the effective use of Post-Exposure Prophylaxis for HIV and the US PEP Clinical Practice Guidelines; (2) support increased public education about the effective use of Post-Exposure Prophylaxis for HIV; and (3) amend policy H-20.900 by insertion as follows:

**HIV, Sexual Assault, and Violence H-20.900**

Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.

(MSS Res 19, A-18)

20.022MSS Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals: AMA-MSS will ask the AMA to support repealing legislation criminalizing non-disclosure of Human Immunodeficiency Virus (HIV) status of people living with HIV who have an undetectable viral load. (MSS Res 41, I-18) (AMA Res 432, A-19, Appended [H-20.914])

20.023MSS Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV: AMA-MSS will ask the AMA to amend AMA Policy H-20.895, Pre-Exposure Prophylaxis (PrEP) for HIV, by insertion to read as follows:

H-20.895 – Pre-Exposure Prophylaxis (PrEP) for HIV

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

(MSS Res. 03, I-19)

20.024MSS Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population: AMA-MSS will ask (1) that our AMA supports the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs, (2) that our AMA recognizes that stable housing promotes adherence to HIV treatment, and (3) that our AMA amend current policy HIV/AIDS as a Global Public Health Priority H-20.922 to state the following:

**HIV/AIDS as a Global Public Health Priority H-20.922**

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

1. Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
2. Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, patient care, and access to
stable housing for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;

(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;

(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;

(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;

(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;

(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;

(8) Supports increased availability of and financial assistance for antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it further; and

(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

(MSS Res. 008, A-22)

25.000MSS Aging

25.001MSS Geriatric Delirium Screening: AMA-MSS will ask the AMA to support efforts to educate physicians regarding the importance of delirium screening for clinically relevant patients 65 years of age or older, using an evidence-based and validated delirium detection tool. (MSS Res 17, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

25.002MSS Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood: AMA-MSS will ask the AMA to encourage appropriate government agencies, nonprofit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible. (MSS Res 6, I-15) (AMA Res 001, A-16 Adopted with Change in Title to “Support Persons with Intellectual Disabilities” [H-90.967]) (Reaffirmed: MSS GC Rep B, A-21)

25.003MSS Increased Affordability and Access to Hearing Aids and Related Care: AMA-MSS will ask the AMA to 1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences to the elderly; 2) encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and 3) support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss. (MSS CEQM Rep I-18, Adopted) (AMA Res 124, A-19, Adopted [H-18.929])

25.004MSS Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido: AMA-MSS will ask the AMA to encourage expansion of research on the use of testosterone therapy and other pharmacological interventions in treatment of decreased libido in post-menopausal individuals.
30.000 MSS  Alcohol and Alcoholism

30.001 MSS  Medical Student and House-Staff Substance Use Disorder: AMA-MSS will ask the AMA to (1) encourage medical schools to provide peer counseling groups for addicted students; (2) aid and support medical schools in the identification of alcohol and drug treatment programs; (3) urge medical schools to grant leaves of absence to addicted students to seek treatment; and (4) support the formation of a national or regional committee of addiction and rehabilitation experts who may evaluate and recommend desirability of readmission for expelled students. (AMA Amended Res 83, I-82 Adopted [H-30.961]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

30.003 MSS  Age Requirement for Purchase of Non-Alcoholic Beer: AMA-MSS will ask the AMA to: (1) support accurate and appropriate labeling disclosing the alcohol content of all beverages including so-called "non-alcoholic" beer and of other substances as well, including over-the-counter and prescription medications with removal of "non-alcoholic" from the label of any substance containing any alcohol; (2) support efforts to educate the public and consumers relating to the alcohol content of so-called "non-alcoholic" beverages and other substances, including medications, especially as related to consumption by minors; and (3) express strong disapproval of any consumption of beer by persons under 21 years of age which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underage use of alcohol. (AMA Amended Sub Res 217, I-91 Adopted [H-30.940]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

30.005 MSS  Boating Under the Influence: AMA-MSS will ask the AMA to (1) support legislation for adequate education on the dangers of alcohol and drug consumption for the safe operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs. (AMA Res 405, I-93 Adopted [H-30.951]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

30.006 MSS  Support of Programs that Discourage Adolescent Alcohol Consumption: AMA-MSS strongly encourages AMA-MSS sections to work with adolescents in their local communities in order to both raise awareness of the dangers of alcohol consumption by minors as well as to curtail underage drinking in their local populations. (MSS Res 28, I-03) (Reaffirmed: MSS Rep E, I-08) Modified: MSS GC Rep B, I-09) (Reaffirmed: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

30.008MSS Support for Medical Amnesty Policies for Underage Alcohol Intoxication: AMA-MSS will ask the AMA to support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking emergency medical attention for themselves or others. (Sub MSS Res 32, I-11) (AMA Res 202, A-12 Adopted as Amended [H-30.938]) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

30.009MSS Sobriety Checkpoints: That our AMA (1) support the use of sobriety checkpoints to deter driving following alcohol consumption; and (2) work with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints. (MSS Res 22, A-14) (AMA Res 202, I-14 Adopted as Amended [H-15.990]) (Reaffirmed: MSS GC Rep A, I-19)

30.010MSS Opposition to Alcoholic Industry Marketing Self-Regulation: Our AMA-MSS will ask our AMA to amend policy H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages, by addition and deletion as follows:

**LABELING, ADVERTISING, AND PROMOTION OF ALCOHOLIC BEVERAGES, H-30.940**

1. (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act. (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underage use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof). (3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports federal and/or state oversight for all forms of alcohol advertising in lieu of the alcohol industry’s current practice of self-regulated advertising and marketing; (b) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b)(c) opposes the use of the radio and television any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; (c)(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d)(e) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and
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from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications. (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (f) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

(MSS Res. 064, Nov. 2020)

30.011MSS Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements: AMA-MSS will ask the AMA to encourage transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria supportable by peer-reviewed and published research.

(MSS Res. 03, I-21)

50.000MSS Blood

50.002MSS Use of Blood Therapeutically Drawn from Hemochromatosis Patients: AMA-MSS will ask the AMA to advocate the acceptance of blood drawn therapeutically from patients with hemochromatosis as a measure to correct the shortage in the blood supply, provided that methods are in place to ensure the donor’s altruistic intent to use the blood for transfusion. (MSS Sub Res 1, I-97) (AMA Res 504, A-98 Referred) (CSA Rep 1, A-99 Adopted) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS Report A, I-17)

50.003MSS Blood Donation by Men who have Sex with Men (MSM): AMA-MSS will ask the AMA to encourage the Food and Drug Administration to continue evaluation and monitoring of regulations on blood donation by men who have had sex with other men, and to consider making modifications to the current deferral policies if sufficient scientific evidence becomes available to support such a change. (MSS Rep A, I-01) (AMA Sub Res 401, A-02 Adopted [H-50.977]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Amended LGBTQ+ Affairs Report A, A-21)
Blood Donor Deferral Criteria Revisions: AMA-MSS will ask that our AMA (1) amend policy H-50.973 by addition and deletion to read as follows:

Blood Donor Deferral Criteria H-50.973

AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of individual risk; and (2) opposes the current lifetime a deferral on blood and tissue donations from men who have sex with men not based in science; and (3) supports research into Individual Risk Assessment criteria for blood donation; and (2) advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for Individual Risk Assessment during the public commentary period. (MSS Res 25, I-16 Immediate Transmittal) (HOD Res. 008, I-16) (Reaffirmed: MSS GC Report A, I-21)

Cancer


Screening and Education Programs for Breast and Cervical Cancer Risk Reduction: AMA-MSS will ask the AMA to (1) support programs to screen all women for breast and cervical cancer; (2) support government funded programs available for low income women; and (3) support the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer. (AMA Amended Res 418, I-91 Adopted [H-55.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (H-55.985 Rescinded: CCB/CLRPD Rep. 3, A-14) (Reaffirmed: MSS GC Rep B, A-21)


Adolescent and Young Adult Cancer: (1) AMA-MSS encourages further research into the scientific basis, treatment, and diagnosis of Adolescent and Young Adult Cancers; and (2) AMA-MSS promotes education and research about the unique challenges to treating adolescents and young adults with cancer, and promote solutions to these challenges. (MSS GC Rep D, A-12) (Reaffirmed: MSS GC Report A, I-17)
Non-Cervical HPV Associated Cancer Prevention: Our AMA-MSS will ask our AMA to: (1) support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV-associated cancers; and (2) amend policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition and deletion as follows:

HPV VACCINE AND CERVICAL CANCER PREVENTION WORLDWIDE, H-440.872
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in all individuals regardless of sex, such as, but not limited to cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccinations by: (a) facilitating administration of HPV vaccinations in community-based setting including school settings, and (b) supporting state mandates for HPV vaccination for school attendance.

Promoting Oral Anti-Cancer Drug Parity: AMA-MSS will ask the AMA to amend Policy H-55.986, Home Chemotherapy and Antibiotic Infusions by addition and deletion as follows:

Home Chemotherapy and Antibiotic Infusions, H-55.986
Our AMA: (1) endorses the use of home medications to include those orally-administered, injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians’ recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician’s clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients, and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings; and (7) advocates for patient cost-sharing parity between office- and home-
administered anticancer drugs.
(MSS Res. 051, A-21)

60.000MSS  Children and Youth

60.001MSS  Medical Family History in Adoptions: AMA-MSS stands in favor of a change in adoption procedures that would require adoption agencies to obtain a complete family medical history and permit the adoptee to have access to this information while still maintaining confidentiality. (MSS Res 1, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

60.002MSS  Provision of Health Care and Parenting Classes to Adolescent Parents: AMA-MSS will ask the AMA to (1) encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings that provide health care for infant and parent and child development classes in addition to current high school courses and (2) support programs directed toward increasing high school graduation rates, improving parenting skills, and decreasing future social service dependence of teenage parents. (AMA Amended Res 422, I-91 Adopted [H-60.973]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

60.006MSS  First Aid Training For Child Daycare Workers: AMA-MSS will ask the AMA to recommend that all licensed child daycare facilities have a minimum of one employee currently certified in first aid including adult/pediatric and infant CPR and foreign body airway management, on site and available during all business hours. (AMA Amended Res 213, I-94 Adopted [H-60.957]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-60.957 Rescinded: CSAPRH Rep. 1, A-14) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


60.010MSS  Encouraging Vision Screenings for Schoolchildren: AMA-MSS will ask the AMA to: (1) encourage and support outreach efforts to provide vision screenings for school-age children prior to primary school enrollment and (2) encourage the development of programs to improve school readiness by detecting undiagnosed vision problems and support periodic pediatric eye screenings with referral for comprehensive professional evaluation as appropriate. (MSS Res 15, A-04) (AMA Amended Res 430, A-05 Adopted [H-425.977]) (Reaffirmed: MSS Res 53, A-15) (Reaffirmed: MSS GC Rep B, A-21)

Establishment of a National Immunization Registry of “Vaccines for Children” Enrolled Patients: AMA-MSS will ask the AMA to (1) work with the Centers for Disease Control, the Department of Health and Human Services, the United States Public Health Service Health, and other interested organizations to develop a National Immunization Registry (NIR) that considers the use of information technology to manage and access information contained within it and (2) ensure that any National Immunization Registry (NIR) that is created protects the patient-physician relationship. (MSS Rep B, A-05) (AMA Sub Res 709, I-05 Adopted [D-440.961]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


Disclosure of Health Status to Children and Adolescents: AMA-MSS will ask the AMA to encourage relevant members of the Federation of Medicine, as well as relevant non-physician organizations, to provide ongoing communication, support, and training to health care providers to assist parents with disclosing their children’s health status, in particular their HIV status, to them in a timely and prudent manner. (MSS Amended Res 5, A-09) (AMA Res 2, I-09 [D-60.970]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Body Image and Advertising to Youth: AMA-MSS will ask the AMA to encourage advertising associations to work with public and private sector organizations concerned with adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image. (MSS Res 26, A-10) (AMA Res 414, A-11 Adopted as Amended [H-60.928]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


60.021MSS Implementation and Funding of Childcare Services for Patients: AMA-MSS will ask the AMA to encourage primary care and emergency department settings, where feasible, to offer inexpensive or free childcare services to patients. (MSS Res 21, A-12) (AMA Res 701, A-13 Not Adopted) (Reaffirmed: MSS GC Report A, I-17)

60.022MSS Altering School Days to Alleviate Adolescent Sleep Deprivation: That our AMA support appropriate entities in establishing clear evidence-based recommendations from existing research on adolescent sleep needs and school start times and that the AMA support legislation congruent with those guidelines. (MSS Res 31, A-14) (AMA Res 404, A-15 Referred) (Reaffirmed: MSS GC Rep A, I-19)

60.023MSS Legal Protection and Social Services for Commercially Sexually Exploited Youth: That our AMA work with state medical societies to (1) advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation, and (2) encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (MSS Res 40, A-14) (MSS Res 4, I-14 Adopted as Amended [D-60.969]) (Reaffirmed: MSS GC Rep A, I-19)

60.024MSS Reporting Child Abuse in Military Families: AMA-MSS will ask the AMA to support all state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense. (MSS Res 22, I-17)

60.025MSS Addressing the Need for Standard Evidence-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression: AMA-MSS will recognize the lack of validated screening tools for pediatric mental illness and promote the research into the validation, development, and implementation of evidence-based routine mental health screenings. (MSS Res 47, A-18)

60.026MSS Support for Children of Incarcerated Parents: AMA-MSS will ask the AMA to support legislation and initiatives that provide resources and support for children of incarcerated parents. (MSS Res 03, I-18) (AMA Res 503, combined with Res 531, A-19, Adopted as amended, [H-60.903])

60.027MSS National Guidelines for Guardianship: AMA-MSS will ask the AMA to collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures. (MSS Res 55 I-18) (AMA Res 19, A-19, Referred)

60.028MSS Ensuring the Best In-School Care for Children with Sickle Cell Disease: AMA-MSS will ask the AMA to (1) support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises, and (2) support the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections. (MSS Res 30, A-19) (AMA Res. 906, Adopt as Amended [H-350.973], I-19)

60.029MSS Affirming the Right of Minors to Consent to Vaccinations: AMA-MSS supports legislation that allows mature minors to provide consent for routine immunizations as recommended by the Centers for Disease Control and Prevention. (MSS Res 48, A-19)
60.030MSS Support for Requiring Investigations into Deaths of Children in Foster Care: AMA-MSS will ask the AMA to support legislation requiring investigations into deaths of children in the foster care system while the child is in the foster care system. (MSS Res 65, I-18) (AMA Res 018, A-19, Adopted [H-60.904])

60.031MSS Increasing Access to Menstrual Hygiene Products in School Settings: AMA-MSS will ask the AMA to (1) recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals and (2) support the distribution of menstrual products and inclusion of menstrual product disposal systems in education institutions. (MSS Res. 41, I-19) (AMA Res. 209, I-21, Adopted [H-525.973])

60.032MSS Opposition of Corporal Punishment as a Form of Discipline: AMA-MSS (1) opposes the use of corporal punishment in any setting and (2) supports education on the negative effects of corporal punishment and education on more effective discipline strategies. (MSS Res. 70, I-19)

60.033MSS Support for Siblings of Chronically Ill Patients: AMA-MSS will ask AMA to support programs and resources that improve the mental health, physical health, and social support for pediatric siblings of chronically ill pediatric patients. (AMA Res. 434, Adopted [I], A-22)

60.034MSS Opposing Efforts that would Prevent Transgender or Questioning Youth from Being Prescribed Puberty-Suppressing Medications by Physicians: AMA-MSS opposes efforts that would prevent transgender or questioning youth from being prescribed puberty-suppressing medications by physicians. (MSS Res. 73, I-19)

60.035MSS Student-Centered Approaches for Reforming School Disciplinary Procedures: AMA-MSS will ask the AMA to (1) support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior and (2) support the inclusion of school-based mental health professionals in the student discipline process. (MSS Res. 83, I-19) (AMA Res. 008, Adopted as Amended [H-60.900], A-22)

60.036MSS Addressing Adverse Effects of Active Shooter Drills on Children’s Health: Our AMA-MSS will ask our AMA to support that all school systems conduct evidence-based active shooter drills in a trauma-informed manner that (a) is cognizant of children’s physical and mental wellness; (b) considers prior experiences that might children’s response to a simulation; (c) avoids creating additional traumatic experiences for children; and (d) provides support for students who may be adversely affected.

Our AMA-MSS will ask our AMA to work with relevant stakeholders to raise awareness of ways to conduct active shooter drills that are safe for children and age appropriate. (MSS Res. 053, Nov. 2020) (AMA Res. 441, Adopted as Amended with Title Change [], A-22)
Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System: Our AMA will amend policy H-60.910, by addition and deletion to read as follows:

ADDRESSING HEALTHCARE NEEDS OF YOUTH CHILDREN IN FOSTER CARE, H-60.910

1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
2. Our AMA advocates that all youth currently in foster care remain eligible for Medicaid or other publicly funded health coverage in their state until at least 26 years of age.

(MSS Res. 097, Nov. 2020)

Reimbursement of School-Based Health Centers: Our AMA will promote the implementation, use, and maintenance of SBHCs by amending H-60.921, School-Based and School-Linked Health Centers as follows:

SCHOOL-BASED AND SCHOOL-LINKED HEALTH CENTERS, H-60.921

1. Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.
3. Our AMA supports identifying SBHCs in claims data from Medicaid and other payers for research and quality improvement purposes. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid.

Pediatric Mental Health Needs during Pandemics: AMA-MSS supports and encourages the research of longitudinal mental health effects of pandemics and other disasters on the pediatric population.

(MSS Res. 007, A-21)
60.040MSS  Formal Transitional Care Program for Children and Youth with Special Healthcare Needs: AMA-MSS will ask the AMA to amend policy H-60.974, Children and Youth with Disabilities, by addition and deletion as follows, to strengthen our AMA policy and to include the population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap:

Children and Youth with Disabilities and with Special Health Care Needs. H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special health care needs (CYSHCN); (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, and CYSHCN, and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations.
(MSS Res. 062, A-21)

60.041MSS  Addressing Longitudinal Health Care Needs of Children in Foster Care: AMA-MSS will ask the AMA to: (1) support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and healthcare professionals; (2) advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care; (3) advocate for pediatrician oversight of local, tribal, and state child welfare systems; and (4) recognize the historical and ongoing disproportionate removal and placement of American Indian and Alaska Native children in foster care.
(MSS Res. 07, I-21) (AMA Res. 443, Adopted as Amended [], A-22)

60.042MSS  Universal Childcare and Preschool: AMA-MSS will ask the AMA to advocate for universal access to high-quality and affordable childcare and preschool.
(MSS Res. 19, I-21) (AMA Res. 405, Adopted as Amended [], A-22)

60.043MSS  Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools: AMA-MSS will ask the AMA to (1) oppose censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restricts mention of sexuality, sexual orientation, or gender identity in schools or educational curricula; and (2) support policies that ensure an inclusive, well-rounded education free from censorship of discussions surrounding sexuality, sexual orientation, and gender identity in public schools.
(MSS Res. 01, A-22)
(Immediately forwarded to HOD, AMA Res. 442, Adopted [], A-22)
65.000MSS  **Civil and Human Rights**

65.002MSS  **Nondiscrimination Based on Sexual Orientation**: AMA-MSS continues to support its positions that nondiscrimination policies are a means for protecting the rights of those that suffer from prejudice. (AMA Res 12, A-89 Adopted [H-295.969]) (Reaffirmed: MSS Rep D, I-99) (Modified: MSS GC Rep A, I-16)


65.007MSS  **Gender-Specific Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System**: AMA-MSS will ask the AMA to work with appropriate organizations to evaluate gender-specific rehabilitation programs, mental health services, and educational services in juvenile detention centers. (MSS Sub Res 10, I-02) (AMA Amended Res 411, A-03 Adopted [H-170.967]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

65.008MSS  **Nondiscriminatory Policy for the Health Care Needs of the LGBTQ+ Community**: AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity” in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity.” (MSS Res 27, A-03) (AMA Res 414, A-04 Adopted [D-65.996]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-19) (Amended: LGBTQ+ Affairs Report A, A-21)

65.009MSS  **Same-Sex and/or Opposite Sex Non-Married Partner**: AMA-MSS will ask the AMA to support legislative and other efforts to allow the adoption by the same-sex and/or opposite sex non-married partner who functions as a second parent or co-parent of children who are born to or adopted by one member. (MSS Res 24, I-03) (AMA Res 204, A-04 Adopted [H-60.940]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

65.010MSS  **Promoting Awareness and Education of LGBTQ+ Health Issues on Medical School Campuses**: AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic
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origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation and/or gender identity or expression. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)

65.011MSS Physician Objection to Treatment and Individual Patient Discrimination: AMA-MSS will ask the AMA to: (1) reaffirm that physicians can conscientiously object to the treatment of a patient only in non-emergent situations; and (2) support policy that when a physician conscientiously objects to serve a patient, the physician must provide alternative(s) which include a prompt and appropriate referral. (MSS Res 14, I-05) (AMA Res 005, A-06 Referred) (CEJA Rep 6, A-07 Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

65.012MSS Removing Barriers to Care for Transgender Patients: AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician. (MSS Amended Res 11, I-07) (AMA Res 122, A-08 Adopted as Amended in Lieu of AMA Res 114 and 115 [H-185.950]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

65.013MSS Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families: AMA-MSS supports AMA efforts to evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is evidence of health care disparities for these couples and children because of their exclusion from civil marriage or (joint) adoption. (MSS Res 5, A-08) (Reaffirmed: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

65.014MSS Marriage Equality and Repeal of the Defense of Marriage Act: (1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those LGBTQ+ individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the “Defense of Marriage Act,” as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the LGBTQ+ community. (MSS Res 30, A-10) (AMA Res 209, I-10 Referred) (Reaffirmed: MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)


65.016MSS Elimination of Health Care Disparities Resulting from Insurance Status: AMA-MSS (1) supports the elimination of health care disparities caused by differential treatment
based on insurance status of Americans; (2) encourages the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; and (3) supports efforts by the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance-based segregation of Medicaid patients in different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations. (MSS Sub Res 29, A-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


65.020MSS Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities: AMA-MSS will ask (1) that our AMA urge long-term care facilities and other appropriate organizations to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations, and (2) that our AMA urge long-term care facilities and other appropriate organizations to provide staff with in-service training to develop a framework to address intimacy in their patient population. (MSS Res 14, I-15) (AMA Res 403, A-16 Adopted) (Reaffirmed: MSS GC Rep B, A-21)

65.021MSS Addressing Patient Spirituality in Medicine: AMA-MSS will ask (1) That our AMA support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health; and (2) That our AMA encourage expanded patient access to spiritual care services and resources beyond trained healthcare professionals. (MSS Res 14, A-16) (Reaffirmed: MSS GC Report A, I-21)

65.022MSS Protection of Transgender Individuals’ Right to Use Public Facilities in Accordance with Their Gender Identity: AMA-MSS supports transgender individuals’ right to use public facilities in accordance with their gender identity to mitigate harms. (MSS Res 01, A-17)

65.023MSS Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals: AMA-MSS will ask that our AMA (1) publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent data and to address unique issues faced by the LGBTQ+ population; (2) promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; (3) amend AMA policy H-65.976 by addition and deletion to read as follows:

**Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H- 65.976**

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual
orientation, sex, or gender identity" in any nondiscrimination statement.

(4) amend AMA policy H-160.991 by addition and deletion to read as follows:

**Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991**

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual, and transgender, queer/questioning, and other (LGBTQ+) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ+; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ+ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ+ patients; (iii) encouraging the development of educational programs in LGBTQ+ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases. and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ+ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ+ people.

(MSS Res. 10, A-17)
FMLA-Equivalent for LGBTQ+ Workers: AMA-MSS will ask the AMA to support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship. (MSS Res 03, I-17) (Amended: LGBTQ+ Affairs Report A, A-21)

Endorsing the Creation of a LGBTQ+ Research IRB Training: AMA-MSS will ask the AMA to work with appropriate stakeholders to support the creation of a model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on LGBTQ+ populations. (MSS Res 09, A-19) (AMA Res. 002, Adopted [D-460.966], I-19)

Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems: AMA-MSS will ask the AMA to amend policy H-315.967, Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation by insertion as follows:

Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s), preferred name, and an inventory of current anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.
(MSS Res 36, A-19) (AMA Res. 004, Adopt as Amended [H-315.967], I-19)

Removing Sex Designation from the Public Portion of the Birth Certificate: AMA-MSS will ask the AMA to advocate for removal of “sex” as a designation on the public portion of the birth certificate and that it be visible for medical and statistical use only. (MSS Res 43, A-19) (AMA Res. 005, Refer for Study, I-19)(BOT Report 15, A-21, Adopted [ ])


Opposing Mandated Reporting of People who Question their Gender Identity: AMS-MSS will ask the AMA to oppose mandated reporting of youth who question or
express interest in exploring their gender identity. (MSS Res 18, I-18) (AMA Res 015, A-19, Adopted [H-65.959])

65.030MSS Sexual and Gender Minority Populations in Medical Research: AMA-MSS will ask the AMA to amend policy H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion and deletion as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation/gender identity, sexual orientation, gender identity, and other sexual and gender minority traits such as intersex of differences of sex development for the purposes of research into patient and population health. (MSS Res 32, I-18) (AMA Res. 242, A-19, Appended [H-315.967]) (Amended: LGBTQ+ Affairs Report A, A-21)

65.031MSS Oppose Requirements of Hormonal Treatments for Athletes: AMA-MSS will ask the AMA to: (1) oppose any regulations requiring mandatory medical treatment or surgery for intersex athletes with Differences in Sex Development (DSD) to be allowed to compete in alignment with their identity; and (2) oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions. (MSS Res 67, I-18) (AMA Res 019, A-19, Referred) (Amended: LGBTQ+ Affairs Report A, A-21)

65.032MSS Patient-Reported Outcomes in Gender Confirmation Surgery: AMA-MSS will ask the AMA to: (1) support initiatives and research to establish standardized protocols for patient selection, surgical management, and pre-operative and post-operative care for transgender patients undergoing gender affirming surgeries; and (2) support development and implementation of standardized tools, such as questionnaires to evaluate outcomes of gender affirming surgeries. (MSS Res 26, I-17) (AMA Res 004, A-18, Adopted [H-460.893]) (Amended: LGBTQ+ Affairs Report A, A-21)

65.033MSS Co-payments in Prisons: AMA-MSS will ask the AMA to advocate for the prohibition of the use of co-payments to access healthcare services in correctional facilities (MSS Res. 04, I-19)

65.034MSS Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies: AMA-MSS will ask the AMA to oppose any lifetime ban on SNAP benefits imposed on individuals convicted of drug-related felonies. (MSS Res. 06, I-19)

65.035MSS Conforming Sex and Gender Designation on Government IDs and Other Documents: AMA-MSS (1) formally supports HOD policy H-65.967, Conforming Sex and Gender Designation on Government IDs and Other Documents; and (2) rescinds policy 65.019MSS, Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients. (MSS Res. 31, I-19)
**Enfranchisement of Incarcerated Persons:** AMA-MSS (1) recognizes that the health and well-being of currently and formerly incarcerated populations, including those convicted of felonies, is connected to the political enfranchisement of those populations; and (2) urges the enfranchisement of formerly and currently incarcerated persons. (MSS Res. 45, I-19)

**Oppose Mandatory DNA Collection of Migrants:** AMA-MSS will ask the AMA to oppose the collection and storage of DNA of refugees, asylum seekers, and undocumented immigrants for non-violent immigration-related crimes without non-coercive informed consent. (MSS Emergency Resolution 01, I-19 – Immediate Forward) (AMA Res. 220, Adopted [H-65.955], I-19)

**Recognizing LGBTQ+ Individuals as Underrepresented in Medicine:** AMA-MSS will ask the AMA to (1) advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident and provider diversity; (2) encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured; and (3) work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (MSS LGBTQ+ MIC Report A, I-19) (AMA Res. 004, Adopted with Title Change [D-200.972], A-22)

**Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity:** Our AMA-MSS will ask our AMA to advocate for the preferential use of community-based, non-custodial Alternatives to Detention programs within the United States that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. (MSS Res. 003, Nov. 2020) (AMA Res. 215, Nov. 2020 – Not Considered) (Reaffirmed: MSS Res. 031, A-21)

**Supporting the Use of Gender-Neutral Language:** Our AMA-MSS will ask our AMA to: (1) Recognize the importance of using gender-neutral language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears, (3) utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. (MSS Res. 018, Nov. 2020) (MSS Res. 015, A-22, Adopt as Amended with Title Change)
Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals: Our AMA-MSS will ask our AMA to amend policy H-185.927, Clarification of Medical Necessity for Treatment of Gender Dysphoria by addition and deletion as follows:

**CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA, 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; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes efforts that criminalize or otherwise restrict evidence-based gender-affirming care or place an undue burden on individuals seeking access to this care.

(MSS Res. 027, Nov. 2020)

Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions:

(1) Our AMA-MSS will ask our AMA to amend policy H-185.990, by addition as follows:

**INFERTILITY AND FERTILITY PRESERVATION INSURANCE COVERAGE, H-185.990**

It is the policy of the AMA that (1) our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility.

(2) Our AMA-MSS will ask our AMA to amend policy H- 185.950 by addition as follows:

**REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS, H-185.950**

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery.

Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Our AMA-MSS will ask our AMA to: (1) study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates; (2) study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates; and (3) support federal legislation that facilitates the study of reparations.

(MSS Res. 054, Nov. 2020) (AMA Res. 005, Refer for Study, A-22)

Banning LGBTQ+ “Panic” Defenses: Our AMA-MSS will ask our AMA to advocate for legislation that would ban the use of LGBTQ+ “panic” defenses in court.

(MSS Res. 078, Nov. 2020)

Equal Access to Adoption for the LGBTQ Community: Our AMA-MSS will ask our AMA to: (1) advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation; and (2) encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity.

(MSS Res. 095, Nov. 2020) (AMA Res. 007, Adopt [D-60.964], A-22)

Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms: Our AMA-MSS will ask our AMA to amend policy H-485.994, “Television Broadcast of Sexual Encounters and Public Health Awareness” by addition and deletion, to read as follows:

TELEVISION BROADCAST AND ONLINE STREAMING OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS ON SOCIAL MEDIA PLATFORMS, H-485.994

The AMA urges television broadcasters and online streaming services, producers, and sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

(MSS Res. 099, Nov. 2020)

Evaluating Scientific Journal Articles for Racial and Ethnic Bias: Our AMA-MSS will ask our AMA to: (1) support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means; and (2) support major journal publishers implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity.

(MSS Res. 118, Nov. 2020) (AMA Res. 011, Adopt as Amended [H-460.885], A-22)

Rectifying the Inequitable and Racist Effects of the Flexner Report: AMA-MSS (1) recognizes the harm created and sustained by the adoption of “The Flexner Report”; (2) creates, distributes, and/or promotes materials that educate about this history; (3) supports the creation of a task force, with representation from stakeholders within and beyond the AMA, to guide our organization’s work to promote true reconciliations, and healing in medicine and medical education; (4) supports funding to support the creation and sustainability of Historically Black College and University (HBCU) and Tribal College and University (TCU) affiliated medical schools and residency
programs with the goal of achieving a physical workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) supports the study of the possibility of including an antiracism competency as part of graduation requirements for LCME- and COCA-accredited medical schools as well as ACGME-accredited residency programs.
(MSS Res. 008, A-21)

65.049MSS  Advocating for the Delivery of Standardized Perinatal Care and Monitoring of Healthcare Outcomes for Incarcerated Pregnant Individuals: AMA-MSS will ask the AMA to (1) encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates; 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.
(MSS Res. 045, A-21)

65.050MSS  The Importance of Consistent Terminology for LGBTQ+ Related Policy and Assessment of Current AMA-MSS Policy on LGBTQ+ Affairs: AMA-MSS will utilize the combined terminology recommendation and catalog of existing AMA-MSS policy to fully update existing AMA-MSS policy relating to LGBTQ+ Affairs to make it consistent with all other policies and the current best practices for language relating to the LGBTQ+ population.
(MSS LGBTQ+ Affairs Report A, A-21)

65.051MSS  Cultural Leave for American Indian Trainees: AMA-MSS will ask the AMA to amend Policy H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition and deletion as follows:

H-310.923 – ELIMINATING RELIGIOUS AND CULTURAL DISCRIMINATION FROM RESIDENCY AND FELLOWSHIP PROGRAMS AND MEDICAL SCHOOLS
Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) Make an effort to accommodate. Allow residents-trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other residents-trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.

AMA-MSS will ask the AMA to work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers.
(MSS Sub. Res. 10, I-21) (AMA Res. 323, Adopted as Amended [], A-22)

65.052MSS  AMA Study of Chemical Castration in Incarceration: AMA-MSS will ask the AMA to study the use of chemical castration in the treatment of incarcerated individuals with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings.
(MSS Res. 29, I-21)
65.026MSS Studying Population-Based Insurance and Payment Policy Disparities: AMA-MSS will (1) support existing AMA policy H-65.961 Principles for Advancing Gender Equity in Medicine given its principles of equitable compensation; (2) support addressing potential insufficiencies in coding and disparities in reimbursement for historically underserved populations including, but not limited to, categorization of services performed by gender, race, ethnicity, ability, or age of the patient; and (3) support addressing insufficiencies in coding and relative valuation for care that may lead to disparities in reimbursement for physicians treating underserved populations, including but not limited to increasing diversity and representation on appropriate decision-making bodies.

(MSS CEQM Rep A, A-22)

65.027MSS Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin: AMA-MSS will ask that the AMA (1) opposes the use of forced or coercive labor practices for incarcerated populations and (2) supports that any labor performed by incarcerated individuals or other captive populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration. (MSS CGPH CBH Report A, A-22)
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75.000MSS  Contraception

75.001MSS  Mandatory Parental Notification for Minors Seeking Contraceptive Devices: AMA-MSS supports the concept that primary prevention of unplanned pregnancy, particularly among the young, is a public health priority; expressed concern that requiring notification and verification of contraceptive care to minors may increase the number of teenagers at risk of unplanned pregnancies by establishing a real or perceived barrier to a primary preventive health service. (MSS Res 21, A-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


75.005MSS  Promotion of Emergency Contraception Pills: AMA-MSS will ask the AMA to: (1) support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women’s groups, health groups, clinics, the public and the media; and (2) advocate programs that provide improved access to emergency contraception pills for women during after-hours need. (MSS Sub Res 54, I-98) (AMA Amended Res 403, A-99 Adopted [D-75.999]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-19)


75.008MSS  Opposition to Sole Funding of Abstinence-Only Education: AMA-MSS will ask the AMA to actively oppose increasing federal and state funding for abstinence-only education, unless future research shows its superiority over comprehensive sex education in terms of preventing negative health outcomes. (MSS Res 31, A-03) (AMA Amended Res 441, I-03 Adopted [H-170.968]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)
Ending Discrimination Against Contraception: AMA-MSS will ask the AMA to support the concept of equity among all forms of prescription contraception in order to offer women the option of affordable contraceptives which would include support from state and federal agencies. (MSS Res 34, I-03) (Reaffirmed Existing Policy in Lieu of AMA Res 107, A-04) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Informed Consent with Regards to Advertising and Prescribing Contraceptives: AMA-MSS: (1) supports continued research that explores alternative mechanisms of contraceptives; and (2) supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods with the addition of information regarding possible secondary mechanisms of contraceptive methods when conclusive and quantitative data is available. (MSS Rep B, A-04) (Reaffirmed: GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception: That our AMA (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling. (MSS 30, A-14) (Reaffirmation A-15; Appended: Res. 502, A-15 Adopted with Change in Title [H-75.987]) (Reaffirmed: GC Rep A, I-19)

Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement: AMA-MSS will ask (1) that our AMA recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies, (2) that our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee, and (3) that our AMA encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures. (MSS Res 10, I-15) (AMA Res 101, A-16 Adopted as Amended [H-75.984]) (Reaffirmed: GC Rep B, A-21)

Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures: AMA-MSS will ask (1) that our AMA recognizes the disparity in pain management in gynecological procedures compared to procedures of similarly reported pain and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision making process and (2) that our AMA supports further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures. (MSS Res. 004, A-22)
90.000MSS  Disabled


90.007MSS  Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization: AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by post-secondary disability resource centers; and (2) will promote utilization of disability resource centers at the post-secondary level for students who meet the requirements established by those centers. (MSS Res 35, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

90.008MSS  Support for Housing Modification Policies: AMA-MSS will ask the AMA to support legislation for health insurance coverage of housing modification benefits for: a) the elderly, and b) other populations including but not limited to the disabled, soon to be disabled, and other person(s) with physical and/or mental disability that require these benefits in order to mitigate preventable health conditions. (MSS COLA Rep A, A-19) (AMA Res. 806, Adopt as Amended [H-160.890]) I-19)
Improving Access to Telehealth for Those with Disabilities: (1) AMA-MSS will ask the AMA to utilize virtual platforms that are accessible to all members, including those with hearing or visual impairment, by using resources such as closed-captioning, magnification, and screen readers; (2) AMA-MSS will support policy ensuring technology companies produce telemedicine software/products that are accessible to persons with disabilities and inline with the interpretation that ADA’s use of the phrase “public accommodation” is not limited to physical structures and may be extended to virtual spaces; (3) AMA-MSS will ask the AMA to amend Policy D-90.992, Preserving Protections of the Americans with Disabilities Act of 1990, by addition as follows:

Preserving Protections of the Americans with Disabilities Act of 1990, D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians and institutions make their offices and telemedicine platforms more accessible to persons with disabilities, consistent with the Americans with Disabilities Act as well as any applicable state laws;
4. AMA-MSS will ask the AMA to amend Policy H-90.971, Enhancing Accommodations for People with Disabilities by addition as follows:

Enhancing Accommodations for People with Disabilities, H-90.971
Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
(MSS Res 002, A-21)

Increase Employment Services Funding for People with Disabilities: AMA-MSS will ask the AMA to support increased resources for employment services to reduce health disparities for people with disabilities.
(MSS Res. 020, A-21)

H-90.968, “Medical Care of Persons with Developmental Disabilities” Amendment: In order to address the shared healthcare barriers of people with disabilities and the need for curricula in medical education on the care and treatment of people with a range of disabilities, the AMA-MSS will ask the AMA to amend by addition and deletion Policy H-90.968, “Medical Care of Persons with Developmental Disabilities” to include those with a broad range of disabilities while retaining goals specific to the needs of those with developmental disabilities:

H-90.968 – MEDICAL CARE OF PERSONS WITH DEVELOPMENTAL DISABILITIES
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for quality, developmentally
appropriate and accessible medical, social and living support for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities, developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities, developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual’s medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of developmental disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical
Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of developmental disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

(MSS Res. 37, I-21) (AMA Res. 428, Adopted [], A-22)

90.012MSS Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients: AMA-MSS will ask the AMA to work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs.

(MSS Res. 003, A-22)

90.013MSS Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis: AMA-MSS will ask (1) that our AMA supports research towards the evaluation and the development of interventions and programs for autistic individuals, (2) that our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism, and (3) that our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:

**Standardizing Coverage for Persons with Autism Spectrum Disorder, H-185.921**

Our AMA supports coverage and reimbursement for evidence-based services for Autism Spectrum Disorder.

(MSS Res. 012, A-22)

90.014MSS Adoption of Accessible Medical Diagnostic Equipment Standards: AMA-MSS will ask that our AMA support the enforcement of proposed federal accessibility standards for medical diagnostic equipment, as well as tax incentives and deductions that help physicians implement these standards. (MSS Res. 020, A-22) (Immediately forwarded to HOD, AMA Res. 526, Adopted as Amended [], A-22)
**95.000MSS Drug Abuse**


**95.002MSS** Methamphetamine Misuse: AMA-MSS will work to educate members on the health impacts of methamphetamine manufacture and misuse and will support national and state legislation that regulates pseudoephedrine availability and accessibility to prevent the use of pseudoephedrine for non-medical purposes. (MSS Res 22, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

**95.003MSS** Marijuana: Medical Use and Research: AMA-MSS will ask the AMA to support reclassification of marijuana’s status as a Schedule I controlled substance into a more appropriate schedule. (MSS Res 2, A-08) (AMA Res 910, I-08 Referred) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

**95.005MSS** Recognition of Addiction as Pathology, Not Criminality: AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease. (MSS Res 31, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

**95.006MSS** Comprehensive Evidence-Based Drug Treatment in Prisons: AMA-MSS will ask the AMA to work with appropriate specialty societies to develop and promote legislative and policy initiatives that expand comprehensive evidence-based substance abuse treatment in federal, state and local prisons and jails. (MSS Res 38, A-12) (HOD Policies H-430.994 and H-430.997 Reaffirmed in Lieu of AMA Res 901) (Reaffirmed: MSS GC Report A, I-17)

**95.007MSS** Increased Advocacy for Needle Exchange Programs: AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows:

H-95.958 Syringe and Needle Exchange Programs

The AMA: (1) encourages needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

95.008MSS Cannabis and the Regulatory Void: AMA-MSS believes that although cannabis is a mind-altering drug whose use may have unforeseen consequences; (1) federal and state governments should abolish all criminal penalties relating to consumption or possession of cannabis; (2) the sale of cannabis for medicinal use should be regulated according to evidence-based research; and (3) additional research should be encouraged. (MSS Res 27, I-12) (Modified: MSS Res 18, A-17)

95.009MSS Addressing Emerging Trends in Recreational Drug Abuse: That our AMA (1) support the appropriate agency to provide continuing medical education courses in emerging trends in recreational substance abuse; and (2) support the appropriate agency to disseminate current and accurate information regarding emerging trends in recreational substance abuse. (MSS Res 16, A-14) (Substitute AMA Res 901, I-14 Adopted with Change in Title [H-95.940]) (Reaffirmed: MSS GC Rep A, I-19)

95.010MSS Eliminating “Fail First” Policy in Addiction Treatment: AMA-MSS will ask that our AMA advocate for the elimination of the “fail first” policy implemented by insurance companies for addiction treatment. (MSS Res 19, A-16) (Reaffirmed: MSS GC Report A, I-21)

95.011MSS Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis: AMA-MSS will ask that our AMA work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. (MSS Res 08, A-17, Immediate Transmittal) (AMA Res 524, A-17, Substitute Resolution Adopted In lieu of Res 513 and 524 [H-95.925])

95.012MSS Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities: AMA-MSS will ask the AMA to advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (MSS Res 06, A-19) (AMA Res. 201, Refer for Study, I-19)

95.013MSS Support Expansion of Good Samaritan Laws: AMA-MSS will ask our AMA to amend policy D-95.977 by insertion to read as follows:

911 Good Samaritan Laws D-95.977

Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan laws.

(MSS Res 37, A-19) (AMA Res. 203, Adopt [D-95.977], I-19)
95.014MSS  Opposition to Lack of Evidence-Based Medicine in Drug Courts: AMA-MSS (1) supports the physician’s role within drug courts for developing specific pharmacological treatment for patients with substance use disorder, and (2) supports physician-patient shared decision-making in addiction treatment planning in all venues, including in the criminal justice system as it regards patients referred to drug courts and those serving probation and on parole. (MSS Res 37, A-18)

95.015MSS  Opioid Treatment Programs Reporting to Prescription Monitoring Programs: AMA-MSS will ask the AMA to amend the policy Opioid Treatment and Prescription Drug Monitoring Programs, D-95.980 by deletion to read as follows:

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980 That our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

(MSS Res 76, I-17) (AMA Res 507, A-18, Referred) (Reaffirmed: CSAPH Rep. 01, A-21, did not include suggested amendment from MSS)

95.016MSS  A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder: AMA-MSS will ask the AMA to urge policy changes at recovery homes to protect patients who use medication for opioid use disorder as prescribed by a provider, including buprenorphine/naloxone combinations, from discrimination against their admittance to recover homes and related resident services. (MSS CGPH CBH Report A, I-19)

95.017MSS  Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Drug Overdoses: Our AMA-MSS will ask the AMA to encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of opioid drug overdoses.


95.018MSS  Use of Involuntary Outpatient Commitment: Our AMA-MSS: (1) recognizes that involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness when all other voluntary means of and barriers to treatment have been explored and (2) supports the monitoring of the effectiveness of local and state involuntary outpatient commitment programs in conjunction with study of barriers to success of voluntary outpatient mental healthcare treatment for individuals who are chronically non-adherent for further research and understanding of evidence-based practices.

(MSS CGPH CBH Rep. A, Nov. 2020)

95.019MSS  Amend D-95.987, to Support Exempting Fentanyl Test Strips and other Drug Checking Technologies from Paraphernalia Laws: AMA-MSS will ask the AMA to amend Policy D-95.987, by addition and deletion as follows:

Prevention of Opioid Drug-Related Overdose, D-95.987
Our AMA: (a) recognizes the great burden that opioid addiction and prescription drug abuse substance use disorders (SUDs) and drug-related overdoses and death place on patients and society alike and reaffirms its support for the compassionate treatment of such patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to implement in order to further develop best practices in this area; and (c) encourages the education of health care workers and people who use drugs opioid users about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.

Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid a drug-related overdose.

Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from opioid addiction a SUD and their friends/families that address harm reduction measures how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Our AMA will advocate for, and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal services.

Support Harm Reduction Efforts through Decriminalization of Possession on Non-Prescribed Buprenorphine: AMA-MSS will ask the AMA to (1) advocate for the removal of buprenorphine from the misdemeanor crime of possession of a narcotic; and (2) support any efforts to decriminalize the possession of non-prescribed buprenorphine.

Drug Policy Reform: AMA-MSS will ask the AMA to: (1) advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies; (2) support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individuals; and (3) support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession.

AMA-MSS will forward this resolution to a future House of Delegates meeting taking place after the HOD considers its upcoming report pursuant to D-95.960, Public Health Impacts of Cannabis Legalization.
Supporting and Funding Sobering Centers: AMA-MSS will ask the AMA to support local, state, and national funding for the development and maintenance of sobering centers to serve as an alternative to emergency departments, hospitalization, or incarceration.
(MSS Res. 17, I-21)

Access to Naloxone for Vulnerable and Underserved Populations: AMA-MSS will support additional research on the most effective methods of naloxone distribution in emergency departments and solutions to overcome barriers to implementation.

That our AMA amend Policy H-420.950, “Substance Use Disorders During Pregnancy” by addition and deletion to read as follows:

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected, and (5) that our AMA support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits.

Addressing the Use of Mail-order Naloxone to Curb the Opioid Epidemic: AMA-MSS will ask that our AMA amend Increasing Availability of Naloxone H-95.932 by addition and deletion as follows:

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.

4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.

5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.

7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.

8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.

9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

10. That our AMA supports efforts to increase the availability, delivery, possession and use of mail-order Naloxone to help prevent opioid-related overdose, especially in underserved communities and American Indian reservations.

(MSS Res. 009, A-22)

Supporting Further Study of Kratom: AMA-MSS will ask that our AMA amend Kratom and its Growing Use Within the United States H-95.934 by addition and deletion as follows:

Our AMA supports efforts to further study the clinical uses, benefits, and potential harms of Kratom, and opposes efforts that may restrict research legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.

(MSS CSI Rep B, A-22)

Drugs

Ethical Concerns and Development of New Medications: AMA-MSS will ask the AMA to support the position that research, development, and submission for the Food and Drug Administration consideration of antiprogestins and other new medications be based predominantly on scientific evidence. (AMA Sub Res 252, A-89 Adopted [H-100.986]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


100.005MSS  Informational Campaign on Diethylstilbestrol - (DES): AMA-MSS will ask the AMA to: (1) encourage education on the consequences of diethylstilbestrol exposure so that medical students and health care professionals receive satisfactory knowledge of the signs and symptoms of DES exposure in both the mother and her children; and (2) support research efforts on DES exposure and the future health of those affected. (MSS Amended Res 1, A-98) (AMA Amended Res 50, I-98 Adopted [H-100.970]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

100.007MSS  Naloxone Administration and Opioid Overdose: AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opioid use disorder places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opioid use disorder; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine. (MSS Rep A, A-05) (AMA Amended Res 526, A-06 Adopted [D-95.987]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

100.008MSS  Novel Antibiotics and Antimicrobial Resistance: AMA-MSS will ask the AMA to continue to monitor the spread of antibiotic resistance and, if deemed necessary, support mechanisms that would result in the timely development of novel antibiotics. Mechanisms should include a combination of push and pull incentives with legislation modeled after the Orphan Drug Act in conjunction with intensive educational efforts targeting physicians and patients. (MSS Rep F, A-08) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 513, A-09) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

100.009MSS  Reporting of Adverse Drug Events: AMA-MSS will ask the AMA to (1) educate physicians about the distinction between adverse events and serious adverse events, as well as the importance of and ethical obligation to report serious adverse events; (2) work with relevant governmental agencies and private organizations to facilitate voluntary physician reporting of adverse drug and medical device events; and (3) encourage the FDA to investigate barriers to physician reporting of serious adverse events. (MSS Sub Res 19, I-09) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 513, A-10) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

100.010MSS  Promoting Prevention of Fatal Opioid Overdose: AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11) (HOD Policy D-95.987 Amended in lieu of AMA Res 503, A-12) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)
AMA-MSS supports the Council on Science and Public Health Report 7, A-12, “Drug Shortages Update,” that contains the following recommendations:

1. Our AMA supports the recommendations of multiple stakeholders’ working in a collaborative fashion to implement these recommendations in an urgent fashion.
2. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.
3. The Council on Science and Public Health continue to evaluate the drug shortage issue and keep the HOD informed about AMA efforts to address this problem.

Our AMA urges the development of a comprehensive federal report on the root causes of drug shortages. Such an analysis should include economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing (Sub MSS Res 41, A-12) (Modified and Reaffirmed: MSS GC Rep A, I-17) (Reaffirmed: MSS GC Rep A, I-19)


AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone. (MSS Res 33, A-15) (AMA Res 909, I-15 Adopted as Amended [H-95.932]) (Reaffirmed: MSS GC Rep B, A-21)

AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies. (MSS Res 21, I-15) (Reaffirmed: MSS GC Rep B, A-21)

AMA-MSS will ask the AMA to support the repeal of the “Anti-Kickback Safe Harbor” for Group Purchasing Organizations. (MSS Res 1, I-15) (AMA Res 201, A-16 Referred for Decision) (Reaffirmed: MSS GC Rep B, A-21)
Opioid Abuse in Breastfeeding Mothers: AMA-MSS (1) will ask that our AMA Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers on the benefits and risks of breastfeeding while using opioid drugs or during maintenance therapy based on the most recent guidelines; and (2) will ask that our AMA amend by addition existing AMA policy H-420.962 Perinatal Addiction – Issues in Care and Prevention to read as follows:

**Perinatal Addiction – Issues in Care and Prevention H-420.962**

Our AMA:

(1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability;

(2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible;

(3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children;

(4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and

(5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

(MSS Res 07, A-17)

Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments: AMA-MSS supports the efforts of the AMA Opioid Task Force and its goal to reduce opioid abuse. (MSS Res 35, A-17)

Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians: AMA-MSS will ask the AMA to support non-fatal and fatal opioid overdose reporting to the appropriate agencies. (MSS Res 10, I-17)

Reforming the Orphan Drug Act: AMA-MSS will ask the AMA to (1) support legislation and policy efforts to reform the Orphan Drug Act by closing loopholes identified by the FDA in order to protect the Act’s original intent of promoting therapies targeting rare diseases; (2) support increased transparency in development costs, post-approval regulation, overall earnings, and off-label uses for pharmaceuticals designated as “Orphan Drugs”; and (3) support efforts to modify the exclusivity period of “Orphan Drugs” in order to increase access to these pharmaceutical drugs. (MSS Res 34-I-17)

Opposing the Classification of Cannabidiol as a Schedule 1 Drug: AMA-MSS will ask the AMA to support the reclassification of Cannabidiol (CBD) as a non-scheduled drug. (MSS Res 64-I-17)
Pharmaceutical Costs H-110.987

(1) Our AMA encourages the Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

(2) Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

(3) Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

(4) Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

(5) Our AMA encourages prescription drug price and transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

(6) Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

(7) Our AMA supports legislation to shorten the exclusivity period for biologics.

(8) Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drugs more affordable for all patients.

(9) Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

(10) Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

(11) Our AMA advocates for policies that prohibit price gouging on prescription medications when there are not justifiable factors or data to support the price increase.

(12) Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as an individual solution or in conjunction with other approaches. (MSS Res 49, A-19) (AMA Res. 802, Amended CMS Report 4 Adopted in Lieu of Res. 802 [H-110.980], I-19)

Supporting Research into the Therapeutic Potential of Psychedelics: AMA-MSS will ask the AMA to 1) call for the status of psychedelics as Schedule 1 substances be reclassified into a lower schedule class with the goal of facilitating clinical research and developing psychedelic-based medicines; 2) given the high regulatory and cultural barriers, explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research; and 3) support and promote research to determine the benefits and adverse effects of long-term psychedelic use. (MSS CSI Rep A, A-19) (AMA Res. 917, Not Adopted, I-19)

Oppose Tracking of People who Purchase Naloxone: AMA-MSS will ask the AMA to oppose any policies that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked or monitored by non-healthcare providers. (MSS Res. 67, I-19) (Reaffirmed: MSS Res. 097, Nov. 2020)

Caps on Insulin Co-Payments for Patients with Insurance: Our AMA-MSS will ask the AMA to amend existing AMA policy H-110.984, Insulin Affordability, by addition and deletion to read:

INSULIN AFFORDABILITY, H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin.
(MSS Res. 011, Nov. 2020) (AMA Res. 118, Adopt as Amended [], A-22)

Advocate for the Legalization of Recreational Cannabis to End Mass Incarceration: Our AMA-MSS supports the legalization of recreational cannabis at the federal level. (MSS Res. 044, Nov. 2020)
Expungement and Sealing of Drug Records: Our AMA-MSS will ask the AMA to amend policy H-95.924, Cannabis Legalization for Recreational Use, by addition and deletion as follows:

CANNABIS LEGALIZATION FOR RECREATIONAL USE, H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (7) support efforts that allow for the expungement, destruction, or sealing of criminal records for legal offenses related to cannabis use or possession; (7') encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (8) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (9) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion; and (10) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

(MSS Res. 087, Nov. 2020) (AMA Res. 216, Nov 2020 – Not Considered)

Towards a Comprehensive Plan to Lower Drug Prices while Preserving Innovation:

AMA-MSS: (1) supports a systematic plan to lower drug prices wherein a statutorily empowered authority would negotiate drug prices with manufacturers, prioritizing the most expensive medications; (2) supports such an authority considering the following information during the course of a negotiation:

(a) the comparative efficacy of the drug relative to the standard of care,
(b) the unmet need of the disease(s) for which the drug is intended to treat,
(c) the costs of the drug’s development and manufacturing,
(d) the amount of public investment used to develop the drug,
(e) the prices charged for the drug in other peer countries if available, considering rebates, discounts, and other price modifications;
(3) supports that these negotiated prices would be used by all public and private insurance providers unless those providers choose to opt-out; (4) supports the imposition of reasonable penalties to enforce pharmaceutical manufacturer compliance with negotiated prices; (5) supports a ban on rebates from pharmaceutical manufacturers to pharmacy benefit managers or a requirement that the savings derived from a rebate must be passed on to insurance plan beneficiaries in their entirety.
Reforming the FDA Accelerated Approval Process: AMA-MSS will ask (1) that our AMA supports mechanisms to address issues in the Food & Drug Administration’s Accelerated Approval process, including but not limited to: efforts to ameliorate delays in post-marketing confirmatory study timelines, the creation of expiration dates for accelerated approvals, protocols for the withdrawal of approvals when post-marketing studies fail, justifications for the use of surrogate endpoints used to demonstrate clinical benefit, and special considerations for certain diseases and (2) that our AMA will support specific solutions to issues in the FDA’s Accelerated Approval process if backed by evidence that such solutions would not adversely impact the likelihood of investment in novel drug development. (MSS Res. 024, A-22) (Immediately forwarded to HOD, AMA Res. 525, Adopted as Amended [], A-22)

Comparative Effectiveness Research: AMA-MSS will ask (1) that our AMA study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter and (2) that our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter. (MSS Res. 035, A-22)

Drugs: Advertising


FDA Regulation of OTC Medication Advertising: AMA-MSS supports increased oversight of over-the-counter medication advertising, applying similar standards that are applied to prescription medication advertising. (MSS Sub Res 2, A-15) (Reaffirmed: MSS GC Rep B, A-21)

Opposing Tax Deductions for Direct-to-Consumer Advertising: AMA-MSS opposes allowing costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes. (MSS Res 05, A-16) (Reaffirmed: MSS GC Report A, I-21)

Pharmaceutical Advertising in Electronic Health Record Systems: AMA-MSS will ask the AMA to 1) encourage the Center for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in EHRs, on physician prescribing, patient safety, health care costs, and EHR access for small practices; and 2) study the ethics of direct to physician advertising at the point of care, including advertising in electronic health record systems. (MSS CHIT/CEQM Rep A, A-19) (AMA Res. 207, Adopt as Amended [D-478.961], I-19)
115.000MSS  Drugs: Labeling and Packaging

115.001MSS  Fingerstick and Single-Use Point-of-Care Blood Testing Devices Should Not Be Used For More Than One Person: AMA-MSS will ask the AMA to encourage improved labeling of fingerstick and point-of-care blood testing devices such that it is clear that multiple-use fingerstick devices made for single patients are intended for use only on single patients. (MSS Res 44, I-10) (AMA Res 515, A-11 Adopted [H-480.951]) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

115.002MSS  Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being: AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed. (MSS Res 24, A-12) (AMA Sub Res 904, I-12 Adopted [D-115.990]) (Reaffirmed: MSS GC Report A, I-17)

115.003MSS  Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts: AMA-MSS will ask the AMA to support research into novel and affordable pharmaceutical packaging in attempts to increase ease of use, improve patient compliance, and decrease abuse potential. (MSS Res 22, I-14) (AMA Res 501, A-15 Adopted as Amended [H-115.967]) (Reaffirmed: MSS GC Rep A, I-19)

120.000MSS  Drugs: Prescribing and Dispensing


120.003MSS  Advocacy for Research into the Effects of Psychotropic Drugs in Children: AMA-MSS will ask the AMA to: (1) work in conjunction with the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and other relevant organizations to encourage increased funding for research into the safety and efficacy of psychotropic medications in children, especially those under 4 years of age, adolescents, and young adults; (2) establish diagnostic criteria for use of these medications in children, adolescents, and young adults; (3) promote incentives to create the infrastructure necessary to carry out studies related to the effects of psychoactive drugs in children, adolescents, and young adults, expressly to train qualified clinical investigators in pediatrics, child psychiatry, and pharmacology; and (4) promote efforts to educate physicians about the appropriate use of psychotropic medications in the treatment of children, adolescents, and young adults. (MSS Amended Res 1, A-00) (AMA Amended Res 504, I-00 Adopted [D-60.995]) (Reaffirmed: MSS Rep E, I-05)(D-60.995 Rescinded: CSAPH Rep. 1, A-10) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
120.005MSS Tracking and Punishing Distributors of Counterfeit Pharmaceuticals: AMA-MSS will ask the AMA to support the Food and Drug Administration’s efforts to research a uniform tracking system for pharmaceuticals and legislation making the production and distribution of counterfeit pharmaceuticals a felony. (MSS Res 35, I-03) (AMA Amended Res 924, I-03 Adopted [D-100.988]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)


120.007MSS Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy: AMA-MSS: (1) supports the American Pharmaceutical Association in ensuring that pharmacies and pharmacists set up systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; and (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference. (MSS Sub Res 23, A-05 Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

120.008MSS Decreasing Epinephrine Auto-Injector Accidents and Misuse: AMA-MSS will ask the AMA to (1) encourage physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and (2) encourage improved product design and labeling of epinephrine auto-injectors. (MSS Res 19, A-10) (AMA Res 513, A-11 Adopted [H-115.968]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

120.009MSS Restrictions on Use of Physician Prescribing Data for Commercial Purposes: AMA-MSS (1) supports limiting the use of physician prescribing data from any and all sources for commercial purposes, including its use by pharmaceutical companies; and (2) supports the availability of physician prescribing data to organizations using it for public health research, law enforcement, adverse effects reporting, and all other noncommercial purposes. (MSS Res 40, A-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

120.010MSS Aligning Prescription Medication Renewals: AMA-MSS will ask the AMA to encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the travel barriers for prescription acquisition. (MSS Res 16, A-12) (AMA Res 801, I-12 Adopted [H-120.952]) (Reaffirmed: MSS GC Report A, I-17)

120.011MSS Personalized Medication Cards: That our AMA support third parties in researching the effectiveness of personalized medication cards, written in a variety of languages for low literacy target audiences, in increasing medication adherence and improving health outcomes. (MSS Res 14, A-14) (AMA Res 906, Adopted as Amended with Change in Title [H-373.993]) (Reaffirmed: MSS GC Rep A, I-19)
120.012MSS Prior Authorization Reform: AMA-MSS supports prescription prior authorization reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or rescission of authorization, portability of prior authorization, and exceptions for urgent care access. (MSS Res 13, I-15) (Reaffirmed: MSS GC Rep B, A-21)


120.014MSS Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs: AMA-MSS will ask that our AMA work with appropriate stakeholders to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level provided these programs follow the quality assurance guidelines set by existing AMA Policy H-280.959. (MSS Res 42, A-17)

120.015MSS Equalizing Reimbursement for Psychotherapy and Drug-Therapy: AMA-MSS supports comparable reimbursement rates per unit of time spent with patients for physician provided psychotherapy and pharmacotherapy where comparable efficacy has been demonstrated. (MSS Res 80-I-17)

120.016MSS Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians: AMA-MSS will ask the AMA to support the creation of national benzodiazepine-specific prescribing guidelines for physicians. (MSS Res 50, A-19) (AMA Res. 908, Not Adopted, I-19)

120.017MSS Expansion of Epinephrine Entity Stocking Legislation: AMA-MSS will ask the AMA to support the adoption of laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of an emergency. (MSS Res. 19, I-19) (AMA Res. 232, Adopted as Amended [], A-22)

130.000MSS Emergency Medical Services

130.002MSS Use of Automatic External Defibrillators: AMA-MSS will ask the AMA to support legislation for the increased use of automatic external defibrillators (AEDs) for the purpose of saving the life of another person in cardiac arrest provided that:

(1) A person or entity who acquires an automatic external defibrillator ensures that:
(A) Expected defibrillator users receive American Heart Association CPR and/or an equivalent nationally recognized course in defibrillator use and cardiopulmonary resuscitation; (B) The defibrillator is maintained and tested according to the manufacturer’s operational guidelines; and (C) Any person who renders emergency care or treatment on a person in cardiac arrest by using an automatic defibrillator activates the emergency medical services system as soon as possible.

(2) Any person or entity who acquires an automatic external defibrillator is encouraged to register the existence and location of the defibrillator with the emergency communications district or the ambulance dispatch center of the primary provider of emergency medical services where the automatic external defibrillator is to be located. (MSS Sub Res 12, A-98) (AMA Res 503, I-98 Referred) (BOT Rep 21, A-99 Adopted in Lieu of Res 503, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)
130.004MSS  Decreasing Emergency Department Overcrowding:
(1) AMA-MSS supports legislation that addresses the issue of emergency department overcrowding and patient boarding.

(2) AMA-MSS will ask the AMA to work with state and federal governments, including agencies such as the Centers for Medicare and Medicaid Services and the U.S. Office of Preparedness and Emergency Operations, to develop guidelines and increase incentives for hospitals to reduce emergency department overcrowding. (MSS Sub Res 2 Adopted in Lieu of MSS Res 2 and MSS Res 7, I-08) (CMS Rep 3, A-09, Adopted in Lieu of AMA Res 719, A-09 [H-130.940]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

130.005MSS  Air Ambulance Regulations and Reimbursements: AMA-MSS will ask that our AMA and appropriate stakeholders study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement. (MSS Res 16, A-17)

130.006MSS  Physician Use of Emergency Lights in Responding to Medical Emergencies: AMA-MSS will ask the AMA to encourage research on the effect of physician use of emergency lights in private vehicles when responding to medical emergencies, which should include effects on response time, patient outcomes and physician motor vehicle safety. (MSS Res 35, A-18)

135.000MSS  Environmental Health


135.003MSS  Recycling in the Medical Community: AMA-MSS will ask the AMA to encourage the medical community to 1) initiate programs to recycle paper, aluminum cans, and bottles to show their commitment to improving the environment; and 2) use recyclable products in lieu of substances shown to be deleterious to the environment. (AMA Sub Res 169, I-89, Adopted [H-135.975]) (Reaffirmed: MSS Rep D, I-99) (H-135.975 Rescinded: CSAPH Rep. 1, A-10) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


Providing Safety-Type Needles for Use in Health Care Settings: AMA-MSS (1) supports efforts to require all health care settings to provide safety-type needles (such as re-sheathable winged steel needles, bluntable needles, retractable needles, or needles with hinged recapping sheaths) as viable alternatives to conventional hypodermic needles for the use of staff and students and (2) recommends that all health care institutions educate and encourage injured persons to report their needle stick injuries to the proper sources so that they might receive appropriate diagnostic and therapeutic care. (MSS Amended Res 33, A-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Toward Environmental Responsibility: AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Statement of Sustainability Principles: AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10) (Reaffirmed: MSS Res 10, I-11) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability: AMA-MSS will ask that our AMA (1) amend policy H-135.949 by addition and deletion to read as follows:

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

(2) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. (MSS Res 23, A-17)
AMA Policy on Investing in the Fossil Fuel Industry: AMA-MSS supports (1) the American Medical Association, Foundation, and any affiliated corporations, to work in a timely and fiscally responsible manner to end all financial investments or relationships with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, to choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers. (MSS Res 33, A-17)

Mitigating Food Waste through Food Recovery: AMA-MSS will ask the AMA to (1) prioritize sustainability and mitigation of food waste in vendor and venue selection and (2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donation. (MSS Res 08, I-17)

Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water: AMA-MSS will ask the AMA to support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (MSS Res 02, A-19) (AMA Res. 901, Adopt Alternate Resolution in Lieu of Res. 901 and Res. 922 [H- 135.916], I-19)

Be the Change: Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership: AMA-MSS will ask the AMA to shift existing all-inclusive paper JAMA to opt-in paper JAMA subscriptions by the year 2020, still giving students an option to receive paper JAMA, while reducing AMA paper waste, supporting a green initiative, and saving cost. (MSS Res 45, I-18) (AMA Res 615, A-19, Referred) (BOT Report 8, Adopted, I-19)

Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room: AMA-MSS will ask the AMA to advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for “single-use” with verified similar safety and efficacy profiles. (MSS Res. 42, I-19)

Protection of Antibiotic Efficacy through Water System Regulation: Our AMA-MSS will study and make recommendations on practices to address contamination, exposure, classification, and clean-up of antibiotics, from public water supplies. (MSS Res. 061, Nov. 2020)
Environmental Contributors to Disease and Advocating for Environmental Justice: AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows:

Research into the Environmental Contributors to Disease and Advocating for Environmental Justice

Our AMA will (1) advocate for the greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

(MSS Res. 019, A-21)

Addressing Inequity in Onsite Wastewater Treatment: AMA-MSS will ask that the AMA (1) supports that federal, state, and local governments abate individual financial and criminal penalties for insufficient wastewater management, especially those placed on underserved communities and American Indian reservations due to environmental racism and socioeconomic disparities; and (2) supports research by federal, state, and local governments to develop strategies to reduce insufficient wastewater management and eliminate detrimental health effects due to inadequate wastewater systems.

(MSS CSI CGPH Rep A, A-22)

Ethics

Bioethics in Medical Education and Practice: It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions regarding his or her own health care and the determination of who makes decisions for health care in the non-competent patient. (MSS Rep C, I-82 Attachment 4) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

140.007MSS  AMA-MSS Support of Advance Directives: (1) AMA-MSS affirms the need for advance directives for all patients, including young adults, and will provide its members with information about advance directives, and recommends medical students complete their own; (2) AMA-MSS will ask the AMA to encourage physicians to discuss advance directives and organ donation with all patients, including young adults, as a part of the ongoing doctor-patient relationship; (3) AMA-MSS will ask the AMA to (a) recommend that advance directives completed by a patient be placed in a prominent area of the patient’s medical record and require EHR providers to provide standardized, easily accessible digital storage space for advance care paperwork; and (b) recommend the inclusion of information on and eligibility requirements pertaining to organ and tissue donation in any advanced directive; (4) AMA-MSS will ask the AMA to support policies and legislation mandating physician reimbursement for time spent discussing advance directives with patients. (MSS Res 27, I-90, MSS Sub Res 59, I-98, MSS Res 20, I-09, MSS GC Rep A, I-06, MSS GC Rep I, I-84, Consolidated: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep A, I-14) (Modified: MSS Res 04, I-16) (Amended, MSS Res. 53, I-21) (Reaffirmed: MSS GC Report A, I-21)


140.013MSS  Out-of-Hospital Do-Not-Resuscitate (DNR) Orders: AMA-MSS supports the rights of terminally and chronically ill patients to have their DNR orders honored by emergency personnel in all out-of-hospital settings in so far that adequate proof and documentation of the patients’ DNR status can be provided in an emergency situation (i.e., medic alert bracelet, etc.). (MSS Amended Sub Res 4, A-97) (Reaffirmed: MSS GC Rep B, I-02) (Reaffirmed: MSS GC Rep C, I-07) (Modified: MSS GC Rep C-I-12) (Reaffirmed: MSS GC Rep A, I-17)

140.019MSS  Supporting the Establishment of Guidelines Regarding Online Professionalism: AMA-MSS will ask the AMA to (1) initiate discussions with partner organizations towards developing a consensus for online professionalism in the medical community that may be used by medical schools to guide the development of policies outlining expectations of professionalism on the Internet for students; and (2) during its efforts to update and modernize the AMA Code of Medical Ethics, include a section regarding online professionalism. (MSS Res 12-I-09) (AMA Res 10-I-09, Adopted [D-478.985]) (D-478.985 Rescinded: CCB/CLRPD Rep. 1, A-13) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)
140.020MSS Increasing Physician Presence in Online Social Networks: AMA-MSS recommends that physicians, medical students, and other members of the medical community educate themselves both about the advantages and increased communication opportunities provided by social networks, but also about the liability and patient confidentiality issues presented. (MSS Res 12, A-10) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

140.023MSS Responsible Biomedical and Bioethics Journalism: AMA-MSS will ask the AMA to (1) encourage responsible biomedical and bioethics journalism; and (2) support the efforts of the Association of Health Care Journalists and other organizations to promote responsible biomedical and bioethics journalism. (GC Rep B, A-10) (AMA Amended Res 606, I-10 Adopted [H-140.854]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

140.024MSS Encouraging Standardized Advance Directives Forms within States: AMA-MSS will ask the AMA to encourage state societies to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients. (MSS Sub Res 18, A-11) (AMA Res 5, I-11 Adopted as Amended [H-85.957]) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

140.025MSS Regulations on the Patenting of Endogenous Human DNA: AMA-MSS will ask the AMA to oppose the patenting of endogenously occurring human DNA or RNA sequences, including specific alleles of such sequences found anywhere within the human population, or DNA and RNA products derived from these sequences. (MSS Res 47, I-11) (Reaffirmed Existing AMA Policy with Amendment in Lieu of Res 504, A-12) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

140.026MSS Assisted Suicide: AMA-MSS recognizes that situations may exist where it would be ethically acceptable for patients to choose to end their own lives. (MSS Res 17, I-12) (Reaffirmed: MSS GC Report A, I-17)

140.027MSS Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education: AMA-MSS will as the AMA to (1) recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; (2) in partnership with appropriate AMA-MSS bodies, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education in bioethics and humanities guided by LCME requirements and the ASBH Task Force; and (3) advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools. (MSS Res 6, A-13) (AMA Policy H-295.961 Reaffirmed in Lieu of AMA Res 902, I-13) (Reaffirmed: MSS GC Rep A, I-19)

140.028MSS Solitary Confinement: That our AMA (1) oppose the use of solitary confinement for juveniles or the mentally ill regardless of circumstance; (2) oppose the use of solitary confinement for disciplinary purposes; and (3) support that isolation for clinical or therapeutic purposes must be conducted under the recommendation and supervision of a physician. (MSS Res 2, A-14) (AMA Res 3, I-14 Adopted as Amended with Change in Title [H-60.922]) (Reaffirmed: MSS GC Rep A, I-19)
140.029MSS  Ethical Parameters for Recommending Mobile Medical Applications: AMA-MSS ask the AMA to examine the issues related to physicians recommending medical software and apps to patients, especially those in which the physician has a vested interest, and to make recommendations as to how to conduct these interactions ethically. (MSS Res 13, A-15) (AMA Res 002, I-15 Reaffirmation) (Reaffirmed: MSS GC Rep B, A-21)

140.030MSS  Ethical Physician Conduct in the Media: AMA-MSS (1) supports a report on the professional and ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; (2) urges the AMA release a statement affirming the professional and ethical obligation of physicians in the media to provide quality medical advice transparent to supporting evidence and conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media; and (3) supports a study existing and potential disciplinary pathways for physicians who violate ethical responsibilities through their communication on a media platform. (MSS Res 25, A-15) (Reaffirmed: MSS GC Rep B, A-21)

140.031MSS  Accommodations for Treatment of Medical Students and Residents: AMA-MSS ask the AMA to study the power-dichotomy between physician and trainee in their position on peers as patients. (MSS Late Res 1, A-15) (AMA Res 003, I-15 Adopted as Amended [D-405.983, then H-295.858]) (Reaffirmed: MSS GC Rep B, A-21)

140.032MSS  Study of the Current Uses and Ethical Implications of Expanded Access Programs: AMA-MSS will ask (1) that our AMA study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies; and (2) that our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies. (MSS Res 08, A-16) (Reaffirmed: MSS GC Report A, I-21)

140.033MSS  Addressing the Importance of Advance Directive Planning and Education for Medical Students: Our AMA-MSS supports undergraduate medical education on end-of-life care, including teaching advance directive planning as a clinical skill through simulation and skills practice, in addition to established didactic modalities. (MSS Res 04, I-16) (Reaffirmed: MSS GC Report A, I-21)


140.035MSS  Proposing Consent for De-Identified Patient Information: AMA-MSS will ask the AMA to study the handling of de-identified patient information by covered entities for third party commercial use and report findings and recommendations back to the AMA House of Delegates (MSS Res 01, I-17) (AMA BOT Rep 26, A-19, Referred)

140.036MSS  Expansion of the Goldwater Rule: AMA-MSS considers it unethical for a physician to offer a professional opinion about specific medical cases on individual patients unless he or she has conducted an examination and has been granted proper authorization for a public media statement. (MSS Res 89-I-17)

140.037MSS  Non-Therapeutic Gene Therapies: AMA-MSS will ask the AMA to partner with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies. (MSS Res 54, I-17) (AMA Res 506, Referred for Decision)
140.038MSS  Ensuring Consent During Educational Physical Exams on Unconscious Patients: Our AMA-MSS: (1) opposes performing physical exams on patients under anesthesia or on unconscious patients when these exams are not urgently medically necessary or without prior consent to do so and (2) supports encouraging institutions to adopt policies that ensure patients are explicitly informed that sensitive physical exams such as breast, pelvic, genitourinary, and rectal exams may occur under anesthesia. (MSS Res. 022, Nov. 2020)

140.039MSS  Ethical Guidance for Short-Term Medical Service Trips: Our AMA-MSS supports fundamental ethical standards for short-term medical service trips that include: (1) ensuring that programs have legitimate community partnerships that guide culturally sensitive and sustainable work based on community-identified needs; (2) volunteer cultural humility training including specific education on the local community norms and the principles of nonmaleficence and beneficence in the context of the trip objectives; and (3) emphasis on empowerment of local communities in the form of health professional and community education.
Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Our AMA-MSS will ask the AMA to amend policy H-430.983 by addition and deletion as follows:

**REDUCING OPPOSING THE USE OF RESTRICTIVE HOUSING IN FOR PRISONERS WITH MENTAL ILLNESS**

Our AMA will: (1) support limiting oppose the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; and (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, human, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

(MSS Res. 094, Nov. 2020)

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**Use of Social Media for Product Promotion and Compensation:** Our AMA-MSS will ask the AMA to study the ethical issue of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal and financial gain.


**Guidelines on Chaperones for Sensitive Exams:** Our AMA-MSS will ask the AMA to ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, “Use of Chaperones in Code of Medical Ethics,” to ensure that it is most in line with the current best practices and potentially considers the following topics: (a) opt-out chaperones for breast, genital, and rectal exams; (b) documentation surrounding the use of chaperones; (c) use of chaperones for patients without capacity; and (d) asking patient’s consent regarding the gender of the chaperone and attempting to accommodate that preference as able.

(MSS Res. 129, Nov. 2020)

**Mandatory Reporting of Sexual Misconduct Allegations to Law Enforcement:** Our AMA-MSS strongly encourages universal mandatory reporting of sexual assault claims when the alleged perpetrator is a health care professional to the appropriate law enforcement agencies.
140.044MSS Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive the AMA Populations: AMA-MSS will ask to: (1) oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, Immigration and Customs Enforcement, and other detention administrators; (2) advocate for the inclusion of physicians in the selection of medications available to vulnerable populations such as incarcerated individuals; and (3) support and work with state medical societies to support measures to increase transparency in medication procurement, including but not limited to: (a) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (b) centralizing formulary choices in a physician-led office, agency, or commission following the principles of a sound formulary.
(MSS CBH CEQM Rep. A, I-21)

145.000MSS Firearms: Safety and Regulation

145.001MSS Handgun Violence: The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard:
(1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns. (Reaffirmed: MSS GC Rep F, I-10) (Consolidated and Reaffirmed Multiple Policies: GC Rep C, I-12)
(Reaffirmed: MSS GC Report A, I-17)

145.004MSS Prevention of Unintentional Firearm Accidents in Children: AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety. (AMA Amended Res 165, I-89 Adopted [H-145.990]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

145.011MSS Gun Safety Counseling in Undergraduate Medical Education: AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education. (MSS Res 2, A-13) (AMA Res 903, I-13 Adopted with Change in Title [H-145.976]) (Reaffirmed: MSS GC Rep A, I-19)

145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks: AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks. (MSS Res 15, A-13) (Reaffirmed: MSS GC Rep A, I-19)

145.013MSS Strengthening our Gun Policies on Background Checks and the Mentally Ill: AMA-MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13) (Reaffirmed: MSS GC Rep A, I-19)

145.014MSS Preventing Fire-Arm Related Injury and Morbidity in Youth: AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting. (MSS Res 30, I-14) (Reaffirmed: MSS GC Rep A, I-19)

145.015MSS Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers: AMA-MSS supports legislation that would expand the current federal prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists. (MSS Res 03, A-18)

145.016MSS Opposition to Armed Campuses: AMA-MSS opposes an increase of firearms on school campuses. (MSS Res 16, A-18)

145.017MSS Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21: AMA-MSS support bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21. (MSS Res 18, A-18)

145.018MSS Development and Implementation of guidelines for Responsible Media Coverage of Mass Shootings: AMA-MSS will ask the AMA to encourage the Center for Disease Control, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. (MSS Res 40, A-18)

145.020MSS Opposing Unregulated, Non-Commercial Firearm Manufacturing: AMA-MSS will ask the AMA to (1) support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and (2) issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue. (MSS Res 07, I-18, HOD I-18 Adopted)

145.021MSS Support for Warning Labels on Firearm Ammunition Packaging: AMA-MSS will ask the AMA to support legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum (a) text-based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms. (MSS Res. 49, I-19) (AMA Res. 233, Adopted [], A-22)

145.022MSSAMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations: AMA-MSS will ask the AMA to amend policy G-640.020 as follows:

G-640.020 – Political Action Committees and Contributions
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC’s policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) will continue to work through its constituent societies to achieve and 100 percent rate of contribution to AMPAC by members; and (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence. (MSS Res. 61, I-19) (AMA Res. 625, Referred, A-22)

145.023MSS Amend H-145.976, to Reimburse Physicians for Firearm Counseling: AMA-MSS will ask the AMA to amend Policy H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams,” by addition as follows:

H-145.976 – FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS
1. Our AMA: (a) will oppose any restrictions on physicians’ and other members of the physician-led health care team’s ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians’ and other
members of the physician-led health care team’s discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.

(MSS Res. 30, I-21) (AMA Res. 436, Adopted as Amended [], A-22)

150.000MSS Foods and Nutrition


150.002MSS Revision of Dietary Guidelines for Americans: AMA-MSS will ask the AMA to: (1) support alterations of “Dietary Guidelines for Americans” only when such alterations are based upon valid medical and scientific principles, and without regard to the economic concerns of the food industry; and (2) recommend that any panel sitting in review of “Dietary Guidelines for Americans” should appoint its membership to avoid possible conflict of interest in accordance with the Federal Advisory Committee Act (5 U.S.C App. 1, Section 5C). (AMA Res 130, A-83, Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

150.003MSS Hunger in America: AMA-MSS will ask the AMA to: (1) reaffirm its opposition to any further decreases in funding levels for maternal and child health programs and (2) reaffirm its interest in continuing to support efforts to identify national food, diet, or nutrient-related public concerns. (AMA Res 132, A-86 Referred) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Rep A, I-19)

150.004MSS Food Substitutes: AMA-MSS will ask the AMA to continue to monitor ongoing studies and future developments concerning substitutes for fat, flour and butter so that physicians can be informed about potential health risks or benefits to their patients before these products are released to the public market. (AMA Res 176, A-88 Adopted [H-150.976]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

150.012MSS  Allergic Reactions in Schools and Airplanes: AMA-MSS will ask the AMA to recommend that (1) all schools provide increased student education on the danger of food allergies; (2) all schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration, be trained and certified in the indications for and techniques of their use; and (3) all commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. (MSS Res 33, A-03) (AMA Amended Res 415, A-04 Adopted [H-440.884]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

150.013MSS  Mercury in Food as a Human Health Hazard: (1) AMA-MSS will ask the AMA to (a) encourage that testing of mercury content in food, including fish, be continued by appropriate agencies, and laboratory reporting of results of mercury testing be updated and consistent with current Environmental Protection Agency and National Academy of Sciences standards; (b) encourage the Food and Drug Administration to determine the most appropriate means of testing and labeling of all foods, including fish, to determine mercury content; and (c) encourage that the results and advisories of any mercury testing of fish should be readily available where fish are sold, including labeling of packaged/canned fish. (2) AMA-MSS supports the AMA encouraging physicians to educate their patients about the potential dangers of mercury toxicity in some food and fish products, especially those that are well documented to contain mercury, and to advise pregnant women to limit and parents to limit their children’s consumption of such products. (MSS Sub Res 34, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)


150.015MSS  Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants and Schools: AMA-MSS will ask the AMA to (1) support the adoption of regulations by the U.S. Food and Drug Administration requiring restaurants with menu items that are standard to multiple locations provide standard nutrition labels for all applicable items, available to their customers on request and (2) support the adoption of regulations by the U.S. Food and Drug Administration requiring all restaurants, school, and work cafeterias to have ingredient lists and nutritional information, including total fat, trans fat, sugar content, and sodium, for all menu

150.017MSS Addition of Alternatives to Soft Drinks in Public Schools: AMA-MSS will ask the AMA to seek to promote the consumption and availability of low calorie, low sugar drinks as a healthy alternative in public schools instead of beverages such as carbonated sodas. (MSS Res 36, I-04) (AMA Amended Res 413, A-05 Adopted [D-150.987]) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

150.020MSS Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods: AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer’s Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer’s markets as part of WIC. (MSS Res 23, I-09) (AMA Res 414, A-10 Adopted [H-150.937]) (Reaffirmed: MSS GC Rep A, A-14) (Reaffirmed: MSS GC Rep A, I-19)

150.021MSS Accurate Reporting of Fats in Nutritional Labels: AMA-MSS will ask the AMA to urge the FDA to use the most accurate and scientific processes to measure the fat content in foods, particularly trans fats and saturated fats, and that the most accurate fat content information based on these processes be included on food labeling. (MSS Sub Res 29, I-09) (AMA Res 412, A-10 Adopted [H-150.939]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

150.022MSS Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners: AMA-MSS will (1) support and advocate for legislation and policies for increased fees and/or taxes on non-alcoholic beverages containing caloric sweeteners; and (2) support the exclusive use of revenue generated from taxes on non-alcoholic beverages containing caloric sweeteners for funding of public health programs designed to combat obesity or public health programs that promote good nutrition. (MSS Res 30, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

150.023MSS Price Parity in Fast Food Children’s Meals: AMA-MSS will ask the AMA to (1) encourage fast food restaurants to establish price parity between traditional side items and alternative, more healthful options in children’s meals; and (2) work directly with the current administration on any relevant initiatives to support the fast food industry in establishing price parity between traditional side items and alternative, more healthful options in children’s meals. (MSS Res 34, I-10) (AMA Sub Res 402 Adopted in Lieu of AMA Resolutions 407 and 402, A-11 [H-150.935 and D-150.977]) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
150.024MSS  **Opposition to Exclusivity Agreements between Junk Food Vendors and Public Schools:** AMA-MSS will ask the AMA to oppose exclusivity agreements between school districts and food and beverage vendors unless those agreements contain provisions mandating that vendors predominantly provide healthful food choices that contribute to the nutritional needs of students. (MSS Res 38, I-10) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 408, A-11) (Reaffirmed: MSS GC Rep A, I-19)

150.026MSS  **Programs to Combat Food Deserts:** AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows:

D-150.978 Sustainable Food

“Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.


150.027MSS  **Harms and Benefits of Vitamin and Mineral Supplements:** AMA-MSS (1) advocates for increased education and awareness regarding the harms and benefits of vitamin and mineral supplements; and (2) supports the study of vitamin and mineral supplement use in primary prevention of chronic disease. (MSS Res 38, A-14) (Reaffirmed: MSS GC Rep A, I-19)

150.028MSS  **Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program:** AMA-MSS will ask the AMA to advocate for positive financial incentives to encourage healthier food purchases for Supplemental Nutrition Assistance Program participants. (MSS Res 35, A-14) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 905, A-15) (Reaffirmed: MSS GC Rep A, I-19)

150.029MSS  **Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Vendor Programs:** AMA-MSS will ask the AMA to support expanding the use of current state and federal food assistance programs (e.g. Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children Fruit and Vegetable Cash Value Voucher; and the US Farm Bill) to include purchasing fruits and vegetables from licensed and/or certified healthy mobile produce vendors. (MSS Res 12, I-14) (Existing Policy Reaffirmed in Lieu of AMA Res 405, A-15) (Reaffirmed: MSS GC Rep A, I-19)
150.030MSS Promoting Food Recovery Efforts in Hospitals: AMA-MSS will ask the AMA to support sustainability, better nutrition and improved community health outcomes through hospital food recovery programs by encouraging state medical societies and physicians to collaborate with local hospitals and food recovery programs present in the community. (MSS Res 21, I-14) (Existing Policy Reaffirmed in Lieu of AMA Res 403, A-15) (Reaffirmed: MSS GC Rep A, I-19)

150.031MSS Standardizing the Use of Expiration Dates on Food: AMA-MSS supports the principle that food dating labels be directed towards consumers in addition to retailers. (MSS Res 17, A-16) (Reaffirmed: MSS GC Report A, I-21)

150.032MSS Defending Federal Child Nutrition Programs: AMA-MSS will ask that our AMA (1) oppose legislation that reduces or eliminates access to federal child nutrition programs; and (2) reaffirm H-150.962 Quality of School Lunch Program. (MSS Res 09, A-17)

150.033MSS Federal Agricultural Subsidy Reform: AMA-MSS supports (1) efforts to limit the consumption of foods and beverages that contain added sweeteners by changes to the federal agricultural subsidies system; and (2) the adjustment of federal subsidies toward the preferential subsidization of crops and food products that are consistent with evidence based guidelines for good nutrition and healthy eating patterns. (MSS Res 30, A-17)

150.034MSS Identifying and Addressing Food Insecurity and Food Deserts Nationwide: AMA-MSS supports (1) research on the impact of factors influencing functional access to food including but not limited to gentrification, transportation, and crime rates on the development of food deserts; (2) the creation of new tools aimed at identifying food deserts taking into account cost of food in geographically accessible stores or modification of existing tools for identification of food deserts to include consideration of affordability in the establishment of accessibility of healthy food sources; and (3) current efforts by the United States Department of Agriculture in the incorporation of nutrition education programs focusing on sustainable food sourcing and the impact of healthy foods on overall well-being including but not limited to those involving school and community garden building and education on healthy eating habits. (MSS Res 46, A-17)

150.035MSS Regulating Front-Of-Package Labels on Food Products: AMA-MSS will ask the AMA to (1) support additional FDA criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits and (2) support the use of front-of-package warning labels on foods that contain excess added sugar. (MSS Res 14, A-18)

150.036MSS Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research: AMA-MSS (1) supports nutrition education programs for Supplemental Nutrition Assistance Program (SNAP) recipients and (2) opposes changes to SNAP that would increase food insecurity such as rigid work requirements or categorical exclusion of individuals who receive SNAP benefits based on their income level. (MSS Res 17, A-18)

150.037MSS Utilizing Food Insecurity Screenings in the Emergency medical setting to identify at Risk Individual: AMA-MSS will study the effectiveness of food prescriptions and
hospital-based food assistance programs for those patients identified as food insecure. (MSS Res 51 I-18)

150.038MSS Eliminating Recommendations to Restrict Dietary Cholesterol and Fat: AMA-MSS will ask the AMA to amend AMA Policy H-150.944, “Combating Obesity and Health Disparities,” by deletion to read as follows:

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and non-dairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol, healthful foods and beverages. (MSS Res 40, I-18) (AMA Res 431, A-19, Not Adopted)

150.039MSS Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities: AMA-MSS will ask the AMA to (1) establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; (2) amend H-60.972 by addition and deletion to read as follows:

Banning Food Commercials Aimed at Children H-60.972

(1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children; and

(2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations.; and

(3) work with appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations. (MSS Res 67, I-17) (AMA Res 409, Adopted with Title Change [H-60.972], Food Advertising Targeted to Youth)

150.040MSS Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S.: AMA-MSS supports evidence-based methods of addressing food insecurity. (MSS CGPH Report A, A-19)

150.041MSS Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality Among Children: AMA-MSS will ask the AMA to advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles. (MSS Res. 05, I-19)

150.042MSS Increased Recognition and Treatment of Eating Disorders in Minority Populations: AMA-MSS will ask the AMA to amend policy H-150.965, by insertion as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions:
H-150.965 – Eating Disorders
The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one’s physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally informed interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating, dieting, and weight restrictive behaviors.

(MSS Res. 84, I-19)

150.043MSS Amending H-150.962, Quality of School Lunch Program, to Advocate for Expansion and Sustainability of Nutritional Assistance Programs during COVID-19: Our AMA-MSS will ask the AMA to amend policy H-150.962, Quality of School Lunch Program by addition as follows:

QUALITY OF SCHOOL LUNCH PROGRAM, 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 support adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic.

(MSS Res. 015, Nov. 2020)

150.044MSS Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925: Our AMA-MSS will ask the AMA to amend policy H-150.925, Food Environments and Challenges Access Healthy Food by addition and deletion as follows:

FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD 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 the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) 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.

(MSS Res. 082, Nov. 2020)

150.045MSS Amend H-150.927, to Include Food Products with Added Sugar: AMA-MSS will ask the AMA to amend Policy H150.927, “Strategies to Reduce the Consumption of Beverages with Added Sweeteners” by addition to read as follows:

H-150.927 – STRATEGIES TO REDUCE THE CONSUMPTION OF FOOD AND BEVERAGES WITH ADDED SWEETENERS
Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes, limiting options to purchase of access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues, restrictions on marketing SSBs and food products with added sugars to children, and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote health beverage and food choices for students; and (5) recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives; and (6) supports that any excise taxes are reinvested in community programs promoting health.

(MSS CSI Rep. A, I-21)

150.046MSS Advocating for Plant-Based Meat Research and Regulation: AMA-MSS will ask that our AMA works with appropriate stakeholders to support plant-based meat research funding.

(MSS COLA CGPH Report A, A-22)

155.000MSS Health Care Costs

155.001MSS Listing of Hospital Charges: AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, housestaff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and (2) recommend that such charges be included on all reporting result sheets and requisition forms.

(AMA Amended Res 75, I-81 Adopted [D-155.990]) (Reaffirmed: MSS COLRP Rep


155.003MSS **Price Transparency in Health Care**: AMA-MSS supports legislation that requires insurance providers to provide an online resource for patients and physicians to calculate charges and out-of-pocket expenses associated with investigations and therapies in an effort to better educate patients and physicians on health care costs, equip patients to recognize value in health care, empower patients to participate in the spending of their health care dollars, and promote one-time and long-term patient savings in an effort to reduce economic strains on health care systems. (MSS Amended Res 8, A-09) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

155.004MSS **Advocating for Research on Physician-Initiated Conversations About Treatment Cost**: That our AMA (1) support the conduction of controlled studies to determine if conversations about cost with patients have any meaningful change on various measures of health outcomes, including but not limited to quality of treatment decisions, liability, and patient satisfaction; and (2) support studies to determine if physicians or health professionals are the appropriate party to initiate such conversations. (MSS Res 18, A-14) (Reaffirmed: MSS GC Rep A, I-19)

155.005MSS **Public Access to Chargemasters**: AMA-MSS supports legislation requiring health-care institutions to provide public online access to their complete and current chargemaster in a searchable, consumer-friendly format that includes reference codes, descriptions, and prices. (MSS Res 04, A-17)

155.006MSS **Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder**: AMA-MSS will ask the AMA to support policy that Applied Behavioral Analysis be classified as a medical intervention, in the context of insurance billing, for the purpose of treating Autism Spectrum Disorder. (MSS Res 22 I-18) (AMA Res 123, A-19, Adopted as amended [H-185.921])

155.007MSS **Increasing Accessibility to Adult Incontinence Products**: AMA-MSS will ask the AMA to support increased access to medically-recognized adult incontinence products through means including, but not limited to Medicare coverage. (MSS Res 24, A-18) (AMA Res 908, I-18, Adopted [H-155.955])

155.008MSS **Providing Reduced Parking Fees for Patients and Trainees**: Our AMA-MSS will ask the AMA to work with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms for reducing parking costs for patients and trainees. (MSS Res. 089, Nov. 2020) (Amended, MSS Res 13, I-21)
155.009MSS  
Amending Policy H-155.955, Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption: AMA-MSS will ask the AMA to amend Policy H-155.955, “Increasing Accessibility to Incontinence Products,” by addition and deletion as follows:

H-155.955 – INCREASING ACCESSIBILITY TO INCONTINENCE PRODUCTS
Our AMA supports increased access to affordable incontinence products, the removal of sales tax on child and adult diapers, including single-use and reusable diapers, and the inclusion of child diapers as qualified medical expenses for HSAs, HRAs, and FSAs.
(MSS Res. 24, I-21) (AMA Res. 231, Adopted as Amended [], A-22)

155.010MSS  
Opposition to Debt Litigation Against Patients: AMA-MSS will ask the AMA to encourage health care organizations to: (1) Manage medical debt with patients directly and consider several options, including assistance applying to coverage, discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before using third-party debt collectors, while avoiding those that harass debtors; (2) Consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to patients’ well-being; and (3) Make multiple attempts to reach and negotiate with patients before proceeding with litigation against patients or any other punitive actions and reserve litigation for patients who are able, but unwilling to pay.
(MSS Res. 26, I-21)

155.011MSS  
Pharmaceutical Drug Pricing: Parameters around Medicare Negotiation and Government Manufacturing of Generic Drugs: (1) AMA-MSS supports the use of the international drug price indices and averages, which may include data from countries regardless of structure of healthcare system or any price controls used, in determining the price and payment for drugs; and (2) AMA-MSS will ask the AMA to support the formation of a non-profit government pharmaceutical manufacturer to produce generic drugs to address market failures, including the existence of small markets for generics, the absence of generics in the market after expiration of patents and exclusivity, and shortages of necessary medications.
(MSS Res. 36, I-21)

160.000MSS  
Health Care Delivery

160.001MSS  
Support of Community Health Clinics with Student Involvement: AMA-MSS will ask the AMA to: (1) endorse the efforts of existing community health clinics with student involvement offering minimal cost, quality primary care; and (2) encourage county and state medical societies to work with medical universities, private practitioners, local health departments, and regional charities to develop more community health clinics of this orientation. (AMA Res 76, A-82 Not Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 50, A-18)

160.002MSS  
Uncompensated Care for the Medically Indigent: AMA-MSS will ask the AMA to support policies that reimburse hospitals for treating patients unable to pay and promote further legislation that establishes such policies. (AMA Res 111, I-85


160.012MSS Readability of Medical Notices of Privacy Practices: AMA-MSS will ask the AMA to (1) continue to support physician efforts to provide Notices of Privacy Practices at an appropriate reading level and in a language appropriate to the patient population served; and (2) make available on its Web site a link to the Health Resources and Services Administration document, Plain Language Principles and Thesaurus for Making HIPAA Privacy Notices More Readable. (MSS Sub Res 9, A-09) (AMA Res 8, I-09 Adopted [H-190.958]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

160.013MSS Adoption of a Universal Exercise Database and Prescription Protocols for Obesity Prevention: AMA-MSS will ask the AMA to (1) collaborate with federal agencies and professional health organizations to develop an independent meta-database of evidence-based exercise guidelines to assist physicians and other health professionals in making exercise prescriptions; and (2) support longitudinal research on exercise prescription outcomes in order to further refine prescription-based exercise protocols. (MSS Res 18, I-09) (AMA Res 415, A-10 Adopted [D-470.991]) (D-470.991 Rescinded: BOT Rep 10, A-14) (Reaffirmed: MSS GC Rep A, I-14) (Amended and Reaffirmed: MSS GC Rep A, I-19)

160.014MSS Recognizing the Important Role of Physician Extenders in the Multidisciplinary Patient Care Team: AMA-MSS (1) recognizes the importance of nurses, nurse
practitioners, and physician assistants to the multidisciplinary patient-care team; (2) recognizes that the physician is the leader of the multidisciplinary patient care team, and that there are distinct differences in training, both in time and content, between physicians and physician extenders; and (3) supports the patient centered medical home model and the role of physicians therein as the primary medical decision makers. (MSS Res 9, A-10) (AMA Amended Res 208, I-10 Adopted [H-310.913]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

160.015MSS Physician Extenders: (1) AMA-MSS opposes any legislation that seeks to expand the scope of practice of physician extenders beyond the level of expertise their training provides, and without the appropriate oversight of a physician; (2) AMA-MSS will ask the AMA to (a) support innovative reimbursement strategies for primary care physicians that reward the use of physician extenders to meet demand for health care services by increasing capacity for delivering care; (b) engage societies of physician extenders to develop consensus recommendations for scope of practice and physician oversight as a means to guide discussions in state and federal legislative bodies; and (c) oppose, in academic environments, payment models for physician extenders that interfere with graduate medical training, such as productivity bonuses and surgical assisting fees. (MSS Res 17, A-10) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

160.016MSS Promoting Internet-Based Electronic Health Records and Personal Health Records: AMA-MSS will ask the AMA to (1) advocate for the integration of provider and hospital electronic health records (EHRs) with Internet-based personal health records (PHRs) as an option for patients; and (2) advocate as a priority for all Internet-based PHRs to be fully HIPAA- compliant. (MSS Res 15, A-10) (AMA Res 809, I-10 Referred) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

160.017MSS Study of Interpreter Mandate: AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English. (MSS Res 20, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

160.018MSS Investigating Cost-Saving, Equitable Care in Direct Practice Medicine: AMA-MSS will ask the AMA to (1) investigate, with the American Academy of Private Physicians, the potential for direct practice medicine to serve as a cost saving tool for certain patients requiring 24-hour access to care; and (2) investigate, with American Academy of Private Physicians, the scope of direct practice medicine and study methods, including partnerships with academic facilities and tax subsidies, to improve the reach of direct practice medicine to include all classes. (MSS Res 27, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

160.019MSS Improved Adequacy of Translation Services in Hospital and Pharmacy Settings: AMA-MSS will ask the AMA to amend policy H-215.982 by deletion and insertion as follows:

H-215.982 Translator Services in Hospitals
Our AMA encourages hospitals health care institutions, including but not limited to hospitals and pharmacies, that serve populations with a significant number of non-English speaking patients to provide trained translator services.


160.024MSS Transportation and Accessibility to Free Medical Clinics: AMA-MSS will ask the AMA to encourage initiatives that address transportation as a barrier to utilization of those institutions addressing the healthcare needs of the underserved in local communities. (Sub MSS Res 25, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 101, A-12) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

160.025MSS Poverty Screening as a Clinical Tool for Improving Health Outcomes: AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources. (MSS Res 20, I-12) (Amended AMA Res 404, A-13 Adopted [H-160.909]) (Reaffirmed: MSS GC Report A, I-17)

160.026MSS Public Reporting of Physician Outcomes: AMA-MSS supports that all programs that publicly report physician outcomes consider a petition process that allows healthcare providers to request exceptions for extreme risk unaccounted for by risk adjustment, and procedures performed for palliative purposes. (MSS Res 13, A-13) (Reaffirmed: MSS GC Rep A, I-19)


160.028MSS Improving Home Health Care: AMA-MSS will ask the AMA to support the establishment of state-based certification for home health care workers and regulatory oversight over home health agencies. (MSS Res 11, I-13) (AMA Res 703, A-14 Referred) (Reaffirmed: MSS GC Rep A, I-19)

160.029MSS Protecting Medical Students’ Rights as Patients: That our AMA amend policy H-315.983 by insertion and deletion as follows: H-315.983 Patient Privacy and Confidentiality
Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

(2) Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

(3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law
enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients’ medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. (16) The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. (17) Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. (18) Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. (19) Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. (20) Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
Including Military History as Part of Standard History Taking: That our AMA (1) encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and (2) support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources. (MSS Res 17, A-14) (Reaffirmed Existing Policy in Lieu of AMA Res 306, A-15) (Reaffirmed: MSS GC Rep B, A-21)

Concurrent Hospice and Life-Prolonging Care: AMA-MSS ask the AMA to amend policy H-85.955 by insertion and deletion as follows:

H-85.955 Hospice Care

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have their designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7) supports changes in the Medicare regulation to allow provision of concurrent curative and hospice care.


Feminine Hygiene Products: Our AMA-MSS supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelters. (MSS Res 17, I-16) (Reaffirmed: MSS GC Report A, I-21)

Expanding Access to Screening Tools for Social Determinants of Health: AMA-MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social


160.035MSS Implementation of Standardized HIPAA Training: Our AMA-MSS supports a standardized HIPAA training curriculum for medical professionals that is transferable between healthcare entities and defines an appropriate time interval for recertification. (MSS Res 45, I-16) (Reaffirmed: MSS GC Report A, I-21)

160.036MSS Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings: AMA-MSS will ask that our AMA encourage the use of trained interpreters as a primary resource for patients with limited English proficiency, when available, in the stead of patient family members and friends. (MSS Res 06, A-17)

160.037MSS Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population: AMA-MSS (1) supports the research efforts to assess the utility and feasibility of state-funded support of Non-Emergency Medical Transportation programs and (2) supports the maintenance of funding for transportation services in state Medicaid programs. (MSS Res 21, A-18)

160.038MSS Supporting Life Narrative Services in Geriatric Patients: AMA-MSS supports the use of narrative services as a way to achieve holistic, compassionate geriatric patient care. (MSS Res 23 I-18)

160.039MSS Addressing Health Disparities Through Improved Transition of Care from Pediatric to Adult Care: AMA-MSS encourages the inclusion of pediatric to adult transition care training in the residency curricula with an emphasis on effective care for vulnerable patient populations such as ethnic and racial minorities. (MSS Res 18, A-19)

160.040MSS Supporting Research into the Use of Mobile Integrated Health Care and Community Paramedicine in Addressing the Primary Care Shortage: AMA-MSS will study mobile medical units as a means of delivering healthcare to underserved communities. (MSS Res 28, I-18)

160.041MSS Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill: AMA-MSS supports policies that promote accessibility of on-site physician home health care for the frail, chronically ill, and low-income populations. (MSS Res 45, A-18)

160.042MSS Support for Standardized Interpreter Training: Our AMA-MSS will ask the AMA to: (1) recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments; (2) encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the AAMC “Guidelines for Use of Medical Interpreter Services”; and (3) work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian
Physicians, National Association of the Deaf, and other relevant stakeholders to develop educational resources, such as through the AMA Ed Hub, for physicians to effectively and appropriately use interpreter services to ensure optimal patient care.

(AMA Res. 310, Adopted [], A-22)

Amending H-160.903, Eradicating Homelessness, to Include Support for Street Medicine Programs and Reduce Evictions: AMA-MSS will ask the AMA to recognize and support the use of Street Medicine programs by amending policy H-160.903, Eradicating Homelessness via addition and deletion as follows:

H-160.903 – ERADICATING HOMELESSNESS Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy of services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
(45) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(56) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(67) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
(78) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(89) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(910) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(911) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; and
(12) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants’ right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries.

(MSS Res. 32, I-21) (MSS Res. 013, A-22, Adopt Substitute Resolution in Lieu of)
Interrupted Patient Sleep: AMA-MSS will ask (1) that our AMA encourages physicians, trainees, inpatient care teams, and hospital administration to reduce the number of patient sleep interruptions as much as possible, including considering the impact of circadian and environmental factors on sleep, to only those interruptions which are necessary and cannot be performed at another time and (2) that our AMA support efforts to improve quality, duration, and timing of inpatient sleep. (MSS Res. 007, A-22)

Promoting a Fragrance-Free Health Care Environment: AMA-MSS will ask (1) that our AMA recognizes fragrance sensitivity as disability where the presence of fragranced products can limit accessibility of healthcare settings, (2) that our AMA encourages all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind, and (3) that our AMA will work with relevant stakeholders to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care. (MSS Res. 026, A-22)

Health System Reform


Steps in Advancing towards Affordable Universal Access to Health Insurance: (1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports Expanding Health Insurance: The AMA Proposal for Reform; (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy. (MSS Rep A, A-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Modified: MSS Res 12, A-17)
Evaluation of the Principles of the Health Care Access Resolution: (1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8) AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Development and Support of Prospective Personalized Health Planning: AMA-MSS will ask the AMA to: (1) continue to recognize the need for possible adaptation of the United States’ health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care models, and measures that will assist in creating a stronger focus on prospective care in the United States’ health care system; and (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing. (MSS Rep F, A-04) (AMA Res 422, A-05 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Covering the Uninsured as AMA’s Top Priority: AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment. (MSS Res 10, I-05) (AMA Amended Res 613, A-06 Adopted [H-165.847]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Report D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Maintaining Insurance Coverage and Empowering State Choice: AMA-MSS (1) supports an individual mandate for health insurance coverage; and (2) supports proposals for state-choice in federal health insurance reform only if they maintain the standards of insurance quality and reach set forward under the 2010 Patients Protection and Affordable Care Act. (MSS Res 43, A-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)
MSS Support for State-by-State Universal Health Care: AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance. (MSS Res 13, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Study of Current Trends in Clinical Documentation: AMA-MSS will ask (1) that our AMA study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation, and (2) that our AMA study current practices for clinical documentation training for physicians as well as in graduate and undergraduate medical education. (MSS Res 12, I-15) (AMA Res 702, A-16 Adopted as Amended) (Reaffirmed: MSS GC Rep B, A-21)

Protecting Patient Access to Health Insurance and Affordable Care: AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to at least 138% of the federal poverty level in states willing to accept expansion, (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (MSS Late Res 01, I-16 Immediate Transmittal AMA Res 224, Substitute Resolution Adopted In lieu of Res 205, 209, 224, and 226 [D-165.935]) (Reaffirmed: MSS GC Report A, I-21)

National Healthcare Finance Reform: Single Payer Solution: (1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS. (MSS Res 12, A-17)

Encourage the Final Evaluation Reports of Section 115 Demonstrations at the End of the Demonstration Cycle: AMA-MSS will ask the AMA to encourage the Centers for Medicare and Medicaid Services to establish written procedures that require finale evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status. (MSS Res 20, A-18)
Expanding AMA’s Position on Healthcare Reform Options: AMA-MSS will ask the AMA to (1) rescind HOD policy H-165.844; (2) rescind HOD policy H-165.985; (3) amend by deletion HOD policy H-165.888 as follows:

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   a. Physicians maintain primary ethical responsibility to advocate for their patients’ interests and needs.
   b. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
   c. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
   d. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan’s policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
   e. And national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
   f. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce and adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
   g. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
   h. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired
Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorder and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of practice, and universal access for patients; and

(4) amend by deletion HOD policy 165.838 as follows: Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: (a) Health insurance coverage for all Americans; (b) Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; (c) Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; (d) Investments and incentives for quality improvement and prevention and wellness initiatives; (e) Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors’ access to care; (f) Implementation of medical liability reforms to reduce the cost of defensive medicine; (g) Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange by self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: (a) Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services; (b) Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential
payment reductions under the Medicare physician payment system; (c) Medicare payment cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted; (d) Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate; (e) Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; (f) arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA’s position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a “call to action” with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government run health care system is not in the best interest of the country and must not be a part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.


165.023MSS Medicare Eligibility at Age 60: AMA-MSS will ask the AMA to advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to 60.

(MSS Res. 006, A-21) (Immediately Forwarded to HOD, HOD Res. 123, A-21, Refer for Study)
Developing a Comprehensive Plan for Health System Reform: AMA-MSS supports the following vision for health systems reform as incremental steps toward a single payer system:

(a) further expansion of fully refundable tax credits for patients to purchase individual insurance, including those intended to reduce premiums and those intended to reduce cost-sharing requirements;

(b) elimination of the income cap for the determination of premium tax credit eligibility;

(c) elimination of the requirement that patients need to lack access to affordable insurance through their employer or public insurance programs in order to qualify for premium tax credits;

(d) encouraging expansion of options that allow employers to provide tax-exempt benefits for employees to enroll in an individual health plan of their choice;

(e) federal requirements that healthcare insurance exchanges include personalized plan cost estimates to enhance price transparency and choice;

(f) state and/or federal reinsurance programs to reduce the cost of insurance;

(g) auto-enrollment in healthcare plans with the highest actuarial value for which prospective enrollees are eligible for coverage at no cost after the application of all relevant subsidies;

(h) the establishment of an affordable public insurance option to be offered by the federal government without regard to income eligibility that achieves the
following goals: (i) expands access to high-quality health insurance coverage; (ii) lowers costs for patients, including premiums and out-of-pocket costs; (iii) only receives the subsidies available to competing insurers; (iv) reimburses hospitals, physicians, and all other healthcare providers at rates sufficient to support their participation without imposing an undue financial burden on those providers; and

(i) all-payer rate negotiation as a means to reduce the cost of healthcare. (MSS Res. 058, A-21)

165.025MSS Movement Away from Employer-Sponsored Health Insurance: Our AMA-MSS will ask our AMA to: (1) recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare; (2) support movement toward a healthcare system that does not rely on employer-sponsored health insurance and enables universal access to high quality healthcare; (3) amend Policy H-165.828, “Health Insurance Affordability,” by addition and deletion to read as follows:

H-165.828 – HEALTH INSURANCE AFFORDABILITY

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee’s premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA’s “family glitch,” thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.

3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.

4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the “family glitch,” and individuals who forego cost-sharing subsidies despite being eligible.

5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

; and (4) amend Policy H-165.823, “Options to Maximize Coverage Under the AMA Proposal for Reform,” by addition and deletion to read as follows:
1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
   a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
   b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
   b.c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
   c.d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid, and/or any commercial product to participation in the public option.
   d.e. The public option is financially self-sustaining and has uniform solvency requirements.
   e.f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
   f.g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
   a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
   b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
   c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
   d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
   e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in the bronze and silver plans to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
(MSS Res. 04, I-21)

165.026MSS Amending Policy on Public Option to Maximize AMA Advocacy: AMA-MSS will ask our AMA to advocate (1) that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed and (2) that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate.
(MSS CAIA Rep B, A-22)
170.000MSS Health Education

170.001MSS Prevention & Health Education: AMA-MSS supports the following principles: (1) Health education should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventive services and health education to employees; (3) All health care professions should be utilized for the delivery of preventive medicine services and health education; (4) Greater emphasis on preventive medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and associated fields should be established, and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) antismoking, (c) enforcement of drunk driving laws, (d) mandatory use of seat belts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and (8) Preventive health services should be made available to all population segments, especially those at high risk. (MSS Rep C, I-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


170.004MSS  Health Education: AMA-MSS will ask the AMA to urge all state medical societies to urge their respective state departments of education to implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and seek funding for these programs. These health education programs should contain provisions for educator training and development of local community health advisory committees. (AMA Sub Res 417, I-91 Adopted [H-170.980]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

170.005MSS  Teaching Sexual Restraint to Adolescents: AMA-MSS will ask the AMA to: (1) support efforts in the mass media, schools, and communities to make abstinent sexual behavior more socially acceptable and to help students develop the skills and self-confidence they need to restrict their sexual behavior; and this support will include efforts to increase funding and policies at the local, state and federal levels, though not necessarily at the expense of existing policies; and (2) encourage school districts to adopt sex education curricula that have a proven record of reducing teenage sexual activity. (AMA Amended Res 407, A-94 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


170.010MSS  Abstinence-Only Education and Federally-Funded Community-Based Initiatives: AMA-MSS supports initiatives to: (1) extend AMA support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in H-170.968; (2) oppose federal funding of community-based abstinence-only sex education programs and instead support federal funding of comprehensive sex education programs that teach about contraceptive choices and safe sex while also stressing the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections; and (3) support school education programs that include recognizing and preventing sexual abuse and dating violence. (MSS Res 23, I-04) (AMA Amended Res 834 Adopted [H-170.968]) (Amended: MSS Late Res 1, A-12) (Reaffirmed: MSS GC Report A, I-17)

170.012MSS Nutrition Education for Parents of School Aged Children: AMA-MSS encourages the development of informational nutrition programs to be implemented through the public school system and methods, such as public service announcements or community awareness campaigns, with the goal to educate parents about healthy lifestyles in an effort to prevent and reduce the prevalence of overweight and obesity in children and adolescents. (MSS Res 7, A-06) (Reaffirmed: MSS Res 46, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

170.013MSS Public School Screening for Childhood Obesity: AMA-MSS will ask the AMA to (1) encourage research and evaluative studies to develop a unified, evidence-based tool to accurately determine youth and adolescent weight status; and (2) encourage wide-scale, comprehensive, school-based obesity prevention that includes didactic curriculum, nutrition standards, physical education programs, and parent and teacher-involvement. (MSS GC Report E, A-07) (AMA Policy Reaffirmed in Lieu of AMA Res 803) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)


170.015MSS Reducing the Risk of Sexually Transmitted Infections in Patients Age 50 and Older: AMA-MSS will ask the AMA to encourage physicians to educate their patients, particularly those of age 50 and older, on safe-sex practices and on the risk of sexually transmitted infections. (MSS Amended Res 16, A-09) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 510, A-10) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

170.016MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula: AMA-MSS will ask that our AMA amend policy H-170.968 by insertion and deletion as follows:

H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

Our AMA: (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (b) show promise for delaying the onset of sexual activity and a reduction in sexual
behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, consent communication to prevent dating violence and reduce substance use while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people, and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on health relationships, sexual health, conversations about consent and substance abuse. (CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09) (MSS Res 24, I-15) (AMA Res 405, A-16 Adopted as Amended with Change in Title to “Sexual Violence Education and Prevention in Schools” [H-170.968]) (Amended and Reaffirmed: MSS GC Rep B, A-21)

170.017MSS Stem Cell Tourism: AMA-MSS will ask (1) that our AMA study best practices for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment, and (2) that our AMA encourage further research on stem cell tourism, and urge physicians to educate themselves on these issues. (MSS Res 28, I-15) (Reaffirmed: MSS GC Rep B, A-21)

170.018MSS Improving Safety and Health Code Compliance in School Facilities: AMA-MSS will ask our AMA to (1) support the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections; (2) support policies aiding schools in meeting said guidelines, including support for
financial and personnel-based aid for schools based in vulnerable neighborhoods; and (3) support creation of a streamlined reporting system for school facility health data potentially through application of current health infrastructure. (MSS Res 09-I-17)

170.019MSS Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula: (1) AMA-MSS encourages school health education programs to emphasize not only HPV association with cervical cancer and genital warts, but also penile, vaginal, vulvar, oropharyngeal, and anal cancers; and (2) AMA-MSS encourages HPV and HPV vaccination school education be more targeted to students at the recommended age of vaccination. (MSS Res 04, A-18)

170.020MSS Sex Education Materials for Students with Limited English Proficiency: Our AMA-MSS will ask our AMA to amend policy H-170.968 by insertion as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternative in birth control, and other issues aimed prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health and conversations about consent;
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

(MSS Res 23, I-17) (AMA Res 414/428 A-18, Appended [H-170.968])

170.021MSS Expansion on Comprehensive Sexual Health Education: Our AMA-MSS will ask the AMA to amend policy H-170.968 by addition and deletion as follows:

SEXUALITY EDUCATION, SEXUAL VIOLENCE PREVENTION, ABSTINENCE, AND DISTRIBUTION OF CONDOMS IN SCHOOLS, H-170.968

1. Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
2. Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer-reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms, dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom
teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, and also teach about including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; (9) Supports the development of sexual education curriculum that integrates dating violence prevention
through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
(MSS Res. 052, Nov. 2020) (AMA Res. 413, Adopted as Amended [A], A-22)

180.000MSS  Health Insurance

180.001MSS  Consumer Choice Principles: AMA-MSS supports the following AMA principles for any consumer choice health plan that might be adopted, as contained in AMA Board of Trustees Rep C (I-82): (1) Multiple Choice of Plans - Insurance Coverage options should be available to employees; accordingly employers, through tax incentives, should be encouraged (but not required) to offer health benefit plans and, if they choose to offer coverage, to offer employees a choice from among multiple options.
(2) Minimum Benefits - Health insurance plans offered to employees should contain required minimum benefits, including catastrophic coverage.
(3) Equal Contributions - Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee.
(4) Non-Taxable Rebate to Employees - Employees should receive a non-taxable rebate where an employee chooses a plan option costing less than the amount of the employer contribution.
(5) Maximum Contribution Limitation - A limit (adjustable for inflation) should be placed on the amount of health insurance premiums paid by an employer for tax deduction by the employer as a business expense. Amounts paid in excess of this limit would be taxable income to the employee.
(6) Employer Non-Compliance - Unqualified plans should not be eligible for tax deduction.
(MSS Rep C, I-82, Attachment 2)

180.002MSS  Prospective Payment/Reimbursement: AMA-MSS endorses the concept of prospective reimbursement as a means of reducing the cost of health care without endorsing any specific plan.

180.003MSS  Equitable Reimbursement for Physicians' Cognitive Services: AMA-MSS supports the concept that third-party payors should provide more equitable reimbursement for physicians' cognitive services.

180.004MSS  Sexual Orientation as Health Insurance Criteria: AMA-MSS will ask the AMA to oppose denial of health insurance on the basis of sexual orientation as well as undue barriers to recommended screening or treatment for conditions for which particular
sexual orientations may be a risk factor. (AMA Res 178, A-88 Adopted [H-180.980])

180.008MSS  Insurance For Domestic Partners: AMA-MSS will ask the AMA to encourage state medical societies to seek legislation in their states that would assure the eligibility of health care benefits for domestic partners, regardless of gender, and their children consistent with the eligibility of spouses of married employees/students and the children of these spouses. (AMA Res 214, I-94 Not Adopted) (Re reaffirmed: MSS Rep B, I-00) (Re reaffirmed: MSS Rep E, I-05) (Re reaffirmed: MSS GC Rep F, I-10) (Re reaffirmed: MSS GC Rep D, I-15) (Amended and Re reaffirmed: MSS GC Rep B, A-21)

180.010MSS  Parity in Health Care for Domestic Partnerships: AMA-MSS will ask the AMA to: (1) encourage the development of domestic partner health care benefits in the public and private sector; (2) support parity of pre-tax health care benefits for domestic partnerships; and (3) support legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision-maker in the Uniform Probate Code in the absence of an alternative health care proxy designee. (MSS Sub Res 6, A-01) (AMA Amended Res 101, I-01 Adopted [H-140.901, H-185.958]) (Re reaffirmed: MSS Rep F, I-06) (Re reaffirmed: MSS GC Rep D-I-11) (Re reaffirmed: MSS GC Report A, I-06) (Re reaffirmed: MSS GC Report A, I-21)

180.012MSS  Expanding Post-Mastectomy Options for Cancer Survivors: AMA-MSS will ask the AMA to recommend that third party payors provide coverage and reimbursement for medically beneficial breast cancer treatments including but not limited to prophylactic contralateral mastectomy. (MSS Res 11, A-02) (AMA Amended Res 107, A-03 Adopted [H-55.978]) (Re reaffirmed: MSS Rep C, I-07) (Re reaffirmed; MSS GC Rep C, I-12) (Re reaffirmed: MSS GC Report A, I-17)


180.014MSS  Antitrust Exemption for Health Insurance Companies: AMA-MSS will ask the AMA to urge federal authorities to oppose antitrust exemption status for health insurance companies. (MSS Res 22, A-12) (Re reaffirmed: MSS GC Report A, I-17)

180.015MSS  Privacy Issues for Minors Regarding Insurance Company Explanations of Benefits: AMA-MSS will ask the AMA to (1) advocate for maintaining privacy regarding the doctor patient relationship for adults and dependents who are insured through their spouse, parent, or guardian, respectively; (2) advocate against allowing insurance companies to send Explanations of Benefits containing sensitive medical information regarding both adults and dependents to anyone other than the patient or their health care provider; and (3) advocate that Explanations of Benefits be made available only if an insurance claim has been denied, in which case the information should be sent directly to the (adult or dependent) patient, who may then choose to discuss it with their physician or share it with their spouse, parent, or guardian. (MSS Res 11, A-13)
180.016MSS Emergency Department Insurance Linking: That our AMA support the establishment of insurance-linking programs in the emergency department in a manner that does not interfere with providing emergency medical services. (MSS Res 32, A-14) (AMA Res 803, I-14 Adopted [H-185.934]) (Reaffirmed: MSS GC Rep A, I-19)

180.017MSS Increasing Access to Medical Devices for Insulin-Dependent Diabetics: AMA-MSS will ask that our AMA work with relevant stakeholders to encourage the development of plans for inclusion in the Medicare Advantage Value Based Insurance Design Model that reduce copayments/coinsurance for diabetes prevention, medication, supplies, and equipment including pumps and continuous glucose monitors, while adhering to existing AMA policies. (MSS Res 04, A-16) (Reaffirmed: MSS GC Report A, I-21)


180.019MSS Researching Policy Recommendations to Address the Shortfalls of Employer-Sponsored Health Insurance: Our AMA-MSS supports transitioning away from a system that relies on employer-sponsored health insurance to facilitate universal access to high-quality, affordable healthcare. (MSS CEQM Rep. C, Nov. 2020)

180.020MSS Increasing Access to Innovative Glucose Monitoring for All Diabetics: AMA-MSS will ask the AMA to amend Policy H-330.885, by addition and deletion as follows:

Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes

Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring systems for all diabetic patients with insulin dependent diabetes by all public insurance programs.

(MSS Res. 032, A-21)

180.021MSS Medicare Coverage of Dental, Vision, and Hearing Services: AMA-MSS will ask the AMA to: (1) support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures and (2) support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses.

AMA-MSS will ask AMA to amend Policy H-185.929, Hearing Aid Coverage by addition as follows:

H-185.929 – HEARING AID COVERAGE

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability, and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams, and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or
physician-led team, aural rehabilitative services, and hearing aids as part of Medicare’s Benefit.

5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.

6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.

7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

(MSS Res. 16, I-21) (AMA Res. 119, Alternate Resolution Adopted in Lieu [], A-22)

180.022MSS Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use: AMA-MSS will ask that our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to:

(a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and

(b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation.

(MSS Res. 033, A-22)

180.023MSS National Fertility Coverage Mandate: AMA-MSS will ask that our AMA amend Policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage” by addition and deletion to read as follows:

1. Our AMA encourages third-party payer health insurance carriers to make available insurance benefits that ensure insurance coverage by all payers for the diagnosis and treatment of recognized male and female infertility.

2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

3. Our AMA will study feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility.

(MSS WIM CEQM Rep B, A-22)

200.000MSS Health Workforce

AMA Opposition to Primary Care Quotas: AMA-MSS will ask the AMA to: (1) strongly oppose primary care quota systems; (2) oppose efforts by federal and state governments that would arbitrarily further control specialties for which medical students may qualify; and (3) continue to support and promote the identification of and funding for incentives to increase the number of primary care physicians. (AMA Sub Res 306, I-92 Adopted in Lieu of Res 325, I-92) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

National Physician Workforce Planning: AMA-MSS will ask the AMA to support the concept that the Council on Graduate Medical Education and/or any equivalent national workforce planning body should be solely advisory in nature and be appointed in a manner that ensures bipartisan representation, including adequate physician representation. (AMA Res 320, I-93 Referred) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

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200.010MSS  Primary Care Internships: AMA-MSS will ask the AMA to encourage state medical societies, in conjunction with primary care specialty societies, to promote and encourage primary care internship and/or preceptorship programs for medical students in their states as a positive means toward increasing the number of primary care physicians. (MSS Rep C, A-94) (AMA Amended Res 307, I-94 Adopted [H-200.973]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


200.015MSS  Supporting the Expansion of U.S. Residency Programs: AMA-MSS supports increases in the number of residency positions according to AMA workforce studies, where such increases would not undermine existing physician residency positions in any of the states. (MSS Amended Sub Res 1, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

200.016MSS  Increasing Medical School Class Sizes: AMA-MSS will ask the AMA to support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (MSS Sub Res 14, I-07) (AMA Res 309, A-08 Adopted [D-295.938]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

200.017MSS  Medical Student Representation in National Health Service Corps Planning: AMA-MSS will advocate to increase medical student representation in the decision-making process of the National Health Service Corps during the implementation of the Patient Protection and Affordable Care Act. (MSS Res 47, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

200.018MSS  Incorporating Community Health Workers into the U.S. Health Care System: That our
AMA (1) encourages the incorporation of community health workers into the U.S. health care system and support legislation that integrates community health workers into care delivery models especially in communities of economically disadvantaged, rural, and minority populations; and (2) supports appropriate stakeholders to define community health workers in order to define their required level of training and scope of practice and to legitimize their role as health care providers. (MSS Res 4, A-14) (AMA Res 805, I-14 Referred) (Reaffirmed: MSS GC Rep A, I-19)

200.019MSS Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems: Our AMA-MSS will ask (1) That our AMA support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts; and (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction. (MSS Res 11, A-16) (Appended: MSS Res. 57, I-19)

200.020MSS Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers: AMA-MSS will ask the AMA to (1) urge the Department of Defense to immediately and publicly release the required assessments that the Military Departments, the Joint Staff, and organizations within the Office of the Secretary of Defense reportedly conducted and submitted in writing by the US Army Surgeon General in Congressional testimony to Senate Appropriations Committee regarding the operational medical requirements needed to support the National Defense Strategy that the Military Departments used in planning to reduce overall uniformed medical positions, as well as provide immediate clarification regarding the proposed cuts including the number of medical provider billet cuts and their distribution amongst specialties and services; and (2) That if no such Department of Defense assessments exist, are immediately released, or appear inadequate to the AMA to justify the proposed cuts to military billets, that the AMA will urgently lobby the US Congress to implement legislation mandating a study in the next National Defense Authorization Act to assess the impact of potential cuts on cost and healthcare quality outcomes for military service members, dependents, and retirees before drastic cuts are executed; and (3) strongly oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for parity civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States’ physician shortage. (MSS Late Resolution 01, A-19, Immediate Forward to HOD, Amended and Adopted by HOD, AMA Res 246 A-19 [H-40.995])

215.000MSS Hospitals

215.001MSS Hospital Dress Codes for the Reduction of Nosocomial Transmission of Disease: AMA-MSS will ask the AMA to advocate for the adoption of hospital guidelines for dress codes that minimize transmission of nosocomial infections, particularly in
critical and intensive care units. (MSS Amended Res 6, I-08) (AMA Res 720, A-09

will ask the AMA to study the extent to which U.S. hospitals inappropriately interfere
in physicians’ independent exercise of medical judgment, including but not limited to
the use of admissions, testing, and procedure quotas. (MSS Res 19, I-13)
(Reaffirmed: MSS GC Rep A, I-19)

215.003MSS Preventive Screening and Treatment of Malnutrition in Hospital Patients:
AMA-MSS will ask the AMA to (1) support the standardization and accreditation of
interdisciplinary nutrition support team services for provision of comprehensive
nutritional screening, assessment, and management in hospitals; (2) support the
establishment of national registries for the sharing of information on prevalence of
malnutrition, health outcomes, costs, and other metrics associated with the
performance of nutrition support teams and other preventive nutritional interventions;
and (3) support the reimbursement of assessment and interventions provided by
nutrition support teams as preventive services where they are used to preclude or
mitigate adverse health outcomes, rather than manage disease-related malnutrition.

215.004MSS Banning the Sale of Sugar-Sweetened Beverages in Hospitals: AMA-MSS supports
measures that restrict retail or vending machine sales of sugar-sweetened beverages in
hospitals, clinics, or food service outlets that operate in space owned by licensed

215.006MSS Amendment to H-150.949 Healthy Food Options in Hospitals: AMA-MSS will ask the
AMA to encourage the availability of healthy, plant-based options at Medical Care
Facilities by amending H-150.949, Health Food Options in Hospitals to read:

Health Food Options in Hospitals Medical Care Facilities H-150.949

(1) Our AMA encourages healthy food options be available, at reasonable prices
and easily accessible, on the premises of hospitals Medical Care Facilities.
(2) Our AMA hereby calls on all hospitals Medical Care Facilities and
Correctional Facilities to improve the health of patients, staff, and visitors by:
(a) providing a variety of healthy food, including plant-based meals, and
meals that are low in fat, sodium, and added sugars; (b) eliminating processed
meats from menus; and (c) providing and promoting healthy beverages.
(3) Our AMA hereby calls for hospital Medical Care Facility cafeterias and
inpatient meal menus to publish nutritional information.

(MSS Res 26, A-19) (AMA Res. 904, Adopt as Amended with Title Change
“Healthful Food Options in Health Care Facilities” [H-150.949], I-19)

215.007MSS The Impact of COVID-19 on the Financial Viability of Various Healthcare Delivery
Systems: AMA-MSS: (1) supports distribution of emergency funding to healthcare
institutions based on proportion of uninsured, uncompensated, and vulnerable
individuals treated and baseline institutional financial needs required to maintain
essential patient care operations during a public health emergency in order to achieve
equitable outcomes; and (2) recommend that hospitals, medical practices, and other
healthcare delivery institutions have an adequate financial security plan and preparedness in the event of a public health emergency to maintain essential operations without producing undue burdens on medical staff that is sustained by: (a) the cash on hand and investments of the institution or (b) in the case that an institution is unable to maintain adequate reserves due to the payer mix or demographics of their population served, that public funding be made available. (MSS CEQM COLA Rep. A, I-21)

245.000MSS Infants Health


245.002MSS AMA Support for Breastfeeding: AMA-MSS will ask the AMA to encourage perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options. (AMA Amended Res 506, A-93 Adopted [H-245.982]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

245.003MSS Sudden Infant Death Syndrome: AMA-MSS will ask the AMA to encourage the education of parents, physicians, and all other health care professionals involved in newborn care regarding methods to eliminate known SIDS risk factors, such as prone sleeping, soft bedding, and parental smoking. (AMA Res 414, A-95 Adopted [H-245.977]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


245.010MSS Safe Haven for Newborns: AMA-MSS supports efforts to lower barriers to adoption including the coordination of anonymous adoption and supports state efforts to decrease the number of abandoned infants by supporting legislation that would protect parents from prosecution who anonymously deliver their infant safely to a licensed health care facility, thus enabling the facility to initiate the adoption process. (MSS Sub Res 5, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)
Protecting a Mother’s Right to Breastfeed: AMA-MSS supports state legislation that clarifies and enforces a mother’s right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother’s right to breastfeed in a public place. (MSS Res 15, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Continuing the Fight to Lower Infant Mortality in the United States: AMA-MSS supports the reduction of the rate of infant mortality in the United States through the promotion of access to prenatal and infant care, education on healthy choices to reduce risks, and research on how to best reduce infant mortality. AMA-MSS will communicate to the AMA Health Disparities Initiative and/or AMA Chief Health Equity Officer the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators. (MSS Res 26, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

Promoting Breastfeeding in Hospitals: AMA-MSS will ask the AMA to: (1) strengthen the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; and (2) encourage hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice “rooming-in,” to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services. (MSS Res 27, I-03) (AMA Amended Res 412, A-04 Adopted [D-245.997]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-245.997 Rescinded: CCB/CLRDPD Rep. 1, A-14) (Reaffirmed: MSS GC Rep A, I-19)


Doctors Defending Breastfeeding: AMA-MSS will ask the AMA to: (1) Discourage hospitals and health care professionals from distributing formula and bottles to women who are willing and able to breastfeed; (2) Oppose the marketing or distribution of infant formula in ways that may interfere with the protection and promotion of breastfeeding; and (3) Recognize the inherent conflict of interest present when infant formula manufacturers provide financial support for research into or professional meetings regarding infant and child feeding. (MSS Res 1, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Early Hearing Detection and Intervention: AMA-MSS will ask the AMA to (1) support Early Hearing Detection and Intervention (EHDI) to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and (2) support federal legislation to provide appropriate resources, coordination, and education for EHDI follow-up with infants who fail
245.018MSS  
Revision of Resuscitation Policies for Premature Infants Born at the Cusp of Viability: AMA-MSS supports programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (MSS Sub Res 9, A-12) (Reaffirmed: MSS GC Report A, I-17)

245.019MSS  
Support for Medicaid Reimbursement of Neonatal Male Circumcision: AMA-MSS will ask the AMA to (1) encourage state Medicaid reimbursement of neonatal male circumcision; and (2) update current policy to support the general principles of the revised 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads “Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV.” (MSS Res 30, I-12) (AMA Res 503, A-13 Adopted [H-60.945]) (Reaffirmed: MSS GC Report A, I-17)

245.020MSS  
Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development: AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in intersex patients and individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making. (MSS Res 17, I-15) (AMA Res 003, A-16 Referred) (Reaffirmed: MSS Res. 086, Nov. 2020) (Reaffirmed: MSS GC Rep B, A-21)

245.021MSS  
The Diaper Gap: AMA-MSS will ask that our AMA support increased access to affordable diapers. (MSS Res 05, A-17)

245.022MSS  
Support for Rooming-In of Neonatal Abstinence Syndrome Patients with their Parents: AMA-MSS will ask the AMA to (1) support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient’s health and safety permits, and as supported by validated risk stratification tools for rooming-in programs; and (2) support the education of physicians about rooming-in patients with neonatal abstinence syndrome. (MSS Res 01, I-18) (AMA Res 525, A-19, Adopted as amended [H-420.949])

245.023MSS  
Opposition to the Immediate Separation of Infants from Incarcerated Pregnant Persons: AMA-MSS will ask the AMA to: (1) oppose the immediate separation of infants from incarcerated pregnant individuals postpartum; and (2) support solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together. (MSS Res. 06, I-21)

250.000MSS  
International Health
250.001MSS    Medical Care in Countries in Turmoil: AMA-MSS will ask the AMA to: (1) support provision of food, medicine, and medical equipment to civilians threatened by natural disaster or military conflict within their country; (2) express concern about the disappearance of physicians, medical students, and health care professionals and withholding of medical care to the injured in such countries in turmoil; and (3) ask appropriate international health organizations to monitor the status of health care in these countries. (AMA Amended Res 133, A-83 Adopted [H-65.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

250.010MSS    Medical Supply Donations to Foreign Countries: (1) AMA-MSS will ask the AMA to encourage the continuing donation of medical equipment, drugs, computers, textbooks, and any other unused medical supplies. (2) AMA-MSS encourages sections to collect medical supplies from their local physicians, hospitals, clinics, etc. (MSS Amended Res 61, I-98) (AMA Res 608, A-99, Referred for decision) (BOT Adopted AMA Res 608, A-99 [D-250.992]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

250.011MSS    Low-Cost Drugs to Poor Countries During Times of Pandemic Health Crisis: AMA-MSS will ask the AMA to: (1) support increased availability of antiretroviral drugs and drugs to prevent active TB infection to countries where HIV/AIDS is pandemic; (2) encourage pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (3) work with the World Health Organization, UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability. (MSS Amended Res 12, I-01) (AMA Res 402, A-02 Adopted [H-250.988]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-19)


250.018MSS    Essential Medicines for the Developing World: AMA-MSS will ask the AMA to (1) support universities engaging nontraditional partners in order to create new opportunities for neglected disease drug development, including public-private partnerships, grant-making organizations, nonprofits, and developing-world research institutions; and (2) support the protection of fair access to essential medicines in developing countries. (Sub MSS Res 4, I-07) (AMA Res 515, A-08 Adopted [H-100.963]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)
250.019MSS  **Global HIV/AIDS Prevention**: AMA-MSS will ask the AMA to (1) support continued funding efforts to address the global HIV epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to prostitution; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention. (MSS Late Res 3, A-08) (AMA Res 438, A-08 Withdrawn) (Reaffirmed: GC Rep B, I-13) (Amended and Reaffirmed: MSS GC Rep A, I-19)

250.020MSS  **Refugee Health Care**: AMA-MSS will ask the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. (MSS Amended Res 4, A-09) (AMA Res 804, I-09 [H-350.957]) (Modified and Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS Res 30, A-18)

250.022MSS  **Foreign Emergency Medical Relief Policy and Procedures for Hospitals**: AMA-MSS will ask the AMA to encourage the American Hospital Association to develop policies and procedures to facilitate the coordination of logistics in the event of an international disaster requiring urgent emergency medical relief. (MSS Res 36, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

250.023MSS  **Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief**: AMA-MSS (1) supports the efforts of the Global Health Service Partnership to strengthen African healthcare workforces; and (2) recognizes the benefits of including loan repayment in the Global Health Service Partnership funded from a variety of sources. (MSS GC Rep E, A-12) (Reaffirmed: MSS GC Report A, I-17)


250.025MSS  **Voluntary Reporting of Complications from Medical Tourism**: AMA-MSS will ask that our AMA ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad. (MSS Res 20, I-15) (AMA Res 703, A-16 Adopted as Amended) (Reaffirmed: MSS GC Rep B, A-21)

250.026MSS  **Research and Monitoring to Ensure Ethics of Global Health Programs**: AMA-MSS will ask that our AMA amend Policy H-250.993 by insertion and deletion as follows:

H-250.993 Overseas Medical Education Developed by US Medical Associations

The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world;
(4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives. (CME Rep. 6, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: CME Rep. 9, A-12)

250.027MSS Emphasizing Training in the Treatment of Refugees: AMA-MSS supports medical student collaboration with appropriate entities for training in the provision of refugee medical care. (MSS Res 08, I-16) (Reaffirmed: MSS GC Report A, I-21)

250.028MSS Increasing Access to Healthcare Insurance for Refugees: AMA-MSS (1) will ask the AMA to support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees, and (2) supports the efforts of federal and state government agencies to facilitate enrollment, or re-enrollment, of eligible refugees into Medicaid, CHIP or Refugee Assistance insurance plans. (MSS Res 05, I-16, First Resolve adopted, Second Resolve Referred) (AMA Res 006, A-17 Adopted [H-350.956]) (Reaffirmed: MSS CGPH Rep A, I-17, second resolve clause added)

250.029MSS Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services: AMA-MSS will ask the AMA to (1) upon the release of any proposed rule or regulations that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and (2) amend AMA policy H-20.901 by addition and deletion to read as follows:

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

(MSS Res 01, A-18) (AMA Res. 254, A-18, Adopted [D-440.927])

250.030MSS Opposing the Office of Refugee Resettlement’s Use of Medical Psychiatric Records for Evidence in Immigration Court: AMA-MSS will ask the AMA to (1) advocate
that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent (MSS Res 15, I-18) (AMA Res 013, A-19, Adopted [H-65.958])

250.031MSS  Supporting Collection of Data on Medical Repatriation: AMA-MSS will ask the AMA to (1) ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriation from the United States to other countries by medical centers and (2) denounce the practice of forced medical repatriation. (MSS Res. 58, I-19) (AMA Res. 209, Adopted as Amended [ ], A-22)

250.032MSS  Promoting Equity in Global Vaccine Distribution: AMA-MSS will ask the AMA to amend Policy H-250.988, Low-Cost Drugs to Poor Countries during Times of Pandemic Health Crises, by addition and deletion as follows:

Aid Low-Cost Drugs to Poor Low- and Middle-Income Countries during Epidemics and Pandemics Times of Pandemic Health Crises, H-250.988
Our AMA will: (1) encourages pharmaceutical companies to work with governmental and appropriate regulatory authorities to encourage (a) the prioritization of equity when providing low cost or free medications, including therapeutics and vaccines, to countries; (b) the temporary waiver of intellectual property protections for necessary medications and other countermeasures; and (c) sharing of equipment, materials, scientific methods, and technological information, to facilitate production and distribution of necessary medications during epidemics and pandemics times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAIDS, and other similar organizations that provide comprehensive assistance, including health care, to low- and middle-income countries in an effort to improve public health and national stability.
(MSS Res. 009/037, A-21) (Immediately Forwarded to HOD as Res. 609, Combined with Res. 608, 610, 611 and Adopted, A-21)

255.000MSS  International Medical Graduates

255.001MSS  The Status of International Medical School Graduates in the United States: AMA-MSS supports the following principles: (1) Immigration legislation should allow adequate time to complete training. (2) Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession. (MSS Position Paper 1, A-83) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended: MSS Res. 107, Nov. 2020) (Reaffirmed: MSS GC Rep B, A-21)

255.002MSS  Foreign Medical School Documentation: AMA-MSS supports the concept that students from non-accredited medical schools be required to adequately document their clinical clerkships as a prerequisite for licensure and ECFMG certification.


Updating AMA-MSS Policies Concerning International Medical Graduates and their Participation in the Physician Profession: Our AMA-MSS: (1) recognizes the important contributions of international medical graduates to the United States health care system; (2) opposes discrimination against medical students, residents, or physicians solely on the basis of national origin and/or the country in which they completed their medical education; (3) supports equal and fair certification for international medical graduates as established by the Educational Commission for Foreign Medical Graduates (ECFMG); and (4) supports that physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character; and (5) supports legislation, policies, and rules that allow international medical graduates to obtain the appropriate visas and licenses to enter graduate medical education and practice medicine within the United States. (MSS Res. 107, Nov. 2020)

IMG Exemptions from Immigration Caps on IMG-Specific Immigration Category for Green Cards and Visas

Our AMA-MSS support the implementation of a healthcare worker VISA category specifically for IMGs and IMSs, which could ease post-VISA foreign residence requirements and allow for appropriate VISA travel guidelines to continue patient care; and be it further
Our AMA-MSS support the creation of broad and accessible IMG-specific bridge programs between education-based and employment-based VISAs to increase retention of J-1 VISA recipients who complete medical training in the US; and be it further
Our AMA-MSS support the implementation of profession-specific or education level exemptions for residents and physicians from the annual caps for EB-1,2 green cards and H-1B temporary work VISAs in order to decrease barriers of non-citizen International Medical Graduates from practicing in the US. (COLA MIC A, A-22)

(Reaffirmed: MSS GC Report A, I-21)

270.004MSS Policy on the "Gag Rule": AMA-MSS will ask the AMA to actively work with  
Congress and other involved organizations to oppose any legislation and/or regulation  
that would interfere with a physician's ability to provide information about all  
treatment options available to their patients, and/or that would interfere with the  
privacy of the physician-patient relationship. (AMA Sub Res 213, A-91 Adopted in  
Lieu of AMA Res 254, A-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep  
(Amended and Reaffirmed: MSS GC Rep B, A-21)

270.006MSS Tax on Health Care Providers: AMA-MSS will ask the AMA to strongly oppose the  
imposition of a selective revenue tax on health care providers by Congress and state  
legislatures in order to fund health care programs. (AMA Amended Sub Res 258, A-  
92, Adopted [H-165.958]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-  
(Reaffirmed: MSS GC Rep B, A-21)

270.010MSS Support of Health Care to Legal Immigrants: AMA-MSS will ask the AMA to  
establish as policy its opposition to Federal and state legislation denying or restricting  
legal immigrants Medicaid and immunizations. (MSS Amended Sub Res 13, I-96)  
(AMA Res 211, A-97 Adopted [H-290.983]) (Reaffirmed: MSS Rep B, I-01)  

270.011MSS Support of Patient Protections: AMA-MSS strongly supports and will promote AMA  
patient advocacy activities including efforts to ensure patient protections in health  
benefit plans. (MSS Rep D, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS  
I-16) (Reaffirmed: MSS GC Report A, I-21)

270.012MSS Opposing Legislation of Medical Procedures: AMA-MSS strongly condemns any  
terference by the government or other third parties that causes a physician to  
compromise his or her medical judgment as to what information or treatment is in the  
best interest of the patient. (MSS Amended Sub Late Res 1, A-97) (Reaffirmed: MSS  
(Reaffirmed: MSS GC Report A, I-17)

270.013MSS Legislation of Medical Procedures: AMA-MSS will ask the AMA to work to ensure  
that if legislation seeks to regulate a medical procedure, the bill language utilizes  
standard medical terminology recognized by physicians to describe the procedure  
precisely. (MSS Amended Sub Res 17, I-97) (AMA Amended Sub Res 203, A-98  

270.016MSS Hate Crimes: AMA-MSS will ask the AMA to recognize that hate crimes pose a  
significant threat to the public health and social welfare of the citizens of the United  
States. (MSS Amended Late Res 8, I-98) (AMA Amended Sub Res 228, I-98  
Adopted [H-65.980]) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08)  

270.019MSS  Implementation of Automated External Defibrillators in High School and College Sports Programs: AMA-MSS will ask the AMA to (1) support state legislation and/or state educational policies encouraging each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator (AED) and trained personnel on its premises; and (2) support state legislation and/or state educational policies encouraging athletic coaches, sports medicine personnel, and student athletes to be trained and certified in CPR, AED, basic life support, and recognizing the signs of sudden cardiac arrest. (MSS Sub Res 5, I-07) (AMA Res 421, A-08 Adopted [D-470.992]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

270.020MSS  Professional Promotion Disclosure Registry: AMA-MSS supports initiatives to create an enforced, transparent, and publicly accessible national registry that would document and itemize individual gifts and payments to physicians from the pharmaceutical, device, and biologic industries; and (2) supports the development of specifications outlining criteria that should be included in any professional promotion disclosure registry in terms of enforcement, transparency, public availability, and reported payments (in accordance with AMA ethical guidelines depicting appropriate payments) to optimize and unify various professional promotion monitoring systems without jeopardizing prescriber-identifiable data. (MSS Rep C, I-08) (AMA Res 6, A-09 Not Adopted) (Modified: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

270.021MSS  National Cosmetics Registry and Regulation: AMA-MSS will ask the AMA to (1) support legislation for the creation of a publicly available national registry of all cosmetics and their ingredients; and (2) support legislation for the FDA to be given strengthened authority to recall cosmetic products determined to be harmful based on the FDA’s product recall classifications. (MSS Amended Res 11, A-09) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

270.022MSS  Promoting Transparency to Stimulate Improved Quality: AMA-MSS will ask the AMA to encourage development of public and hospital-based reporting systems that create transparency into individual physician performance to stimulate quality improvement and better-informed patient and physician decision-making. (MSS Res 13, A-10) (AMA Policies Reaffirmed in Lieu of AMA Res 808, I-10) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

270.025MSS  Protecting the Patient and Physician Relationship from Legislative Regulation: AMA-MSS (1) opposes legislation that requires physicians to perform medical procedures without valid medical indication or contrary to standards of care, especially as it concerns mandates to perform fetal ultrasounds on patients; and (2) opposes legislation that mandates specific counseling by physicians to patients, including mandatory viewing and description of fetal ultrasound images or required listening of fetal heart sounds. (MSS Res 10, A-12) (Reaffirmed: MSS GC Report A, I-17)

270.026MSS  Strongly Advocate for Federal Funding for Indian Health Services: AMA-MSS (1) supports increased federal funding for Indian Health Service programs that directly influence medical student education opportunities; (2) supports AMA advocacy that all of the facilities that serve American Indian and Alaska Native populations under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers; and (3) supports the AMA partnering with recognized American Indian health advocacy organizations like the National Indian Health Board, the National Congress of American Indians, and the Association of American Indian Physicians to advocate for increased funding for Indian Health Services in Congress. (MSS Res 27, A-13) (Reaffirmed: MSS GC Rep A, I-19)

270.028MSS  Opposition to Disclosure of Substance Use Disorder Treatment History in Public Assistance Programs: Our AMA-MSS will ask as the AMA to amend policy H-270.966 by insertion and deletion as follows:

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H-270.966 Disclosure of Drug Use and Addiction Substance Use Disorder Treatment History in Public Housing Applications Assistance Programs

The AMA opposes: a) Section 301-d (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies that require that housing applicants consent to the disclosure of medical information about alcohol and/or substance use disorder treatment as a condition of renting or receiving Section 8 assistance, and seeks its removal and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, “welfare”) and/or the Supplemental Nutrition Assistance Program (SNAP, “food stamps”) to disclose medical information, including alcohol and/or substance use disorder treatment for addiction or to deny assistance from these programs based on substance use disorder status.

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270.029MSS  AMA Support for Justice Reinvestment Initiatives: AMA-MSS will ask that our AMA support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs. (MSS Res 23, I-15) (AMA Res 205, A-16 Adopted as Amended [H-95.931]) (Reaffirmed: MSS GC Rep B, A-21)

270.030MSS  Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States’ Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability: Our AMA-MSS will ask (1) that our AMA advocate that the “deficit-
neutrality” component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and (2) that our AMA study reforms that can be introduced under Section 1332 of the ACA in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same. (MSS Res 07, A-16) (Reaffirmed: MSS GC Report A, I-21)

270.031MSS Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers: AMA-MSS will ask (1) that our AMA advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Federal Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system; (2) that our AMA support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and (3) that our AMA advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs. (MSS Res 22, A-16) (AMA Res 809, I-16 Adopted as Amended [H-100.950]) (Reaffirmed: MSS GC Report A, I-21)

270.032MSS Paid Parental Leave: Our AMA-MSS (1) supports policy that extends the length of universal paid parental leave, recommending especially a period of 14 weeks or longer; and (2) supports policies that equally encourage parents of all genders to take parental leave. (MSS Res 10, I-16) (Reaffirmed: MSS GC Report A, I-21)

270.033MSS Increased Oversight of Suicide Prevention Training for Correctional Facility Staff: AMA-MSS will ask that our AMA (1) strongly encourage all state and local correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care guidelines; and (2) strongly encourage all state and local correctional facility officers to undergo suicide prevention training annually. (MSS Res 16, I-16) (AMA Res 408, A-17 Adopted as Amended [H-430.984]) (Reaffirmed: MSS GC Report A, I-21)

270.035MSS Opposition to Capital Punishment: AMA-MSS opposes all forms of capital punishment. (MSS Res 34, A-17)

270.036MSS Evaluating Legislation on Substance Disorder Treatment Privacy and Confidentiality: AMA-MSS supports the study of the implications of 42 CFR Part 2 under current law, as well as the proposed alignment of substance use disorder confidentiality requirements with HIPAA, with respect to:

1) Harm due to unwanted disclosure of Substance Use Disorder (SUD) diagnosis and treatment information, including legal, social, emotional, and psychological outcomes;
2) Harm due to non-disclosure of Substance Use Disorder (SUD) diagnosis and treatment information to other health care providers; and
3) Deterrence of patients from seeking treatment for SUDs. (MSS Res 57-I-17)
270.037MSS  
Support for Continued 911 Modernization and the National Implementation of Test-To-911 Service: AMA-MSS will ask the AMA to support the funding of federal grant programs for the modernization of 9-1-1 infrastructure, including incorporation of text to 911 technology. (MSS Res 15, A-18)

270.038MSS  
Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs: AMA-MSS will ask the AMA to: (1) support reductions in and exemptions from work requirements used as eligibility criteria in the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families program (TANF); and (2) support states’ ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program. (MSS Res. 10, I-19)

270.039MSS  
Study of Medical Student, Resident/Fellow, and Physician Voting in Federal, State, and Local Elections: AMA-MSS will ask the AMA to study the rate of voter turnout of physicians, residents, fellows, and medical students in federal, state, and local elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community. (MSS Res. 14, I-19) (AMA Res. 616, Adopted as Amended with Title Change [], A-22)

270.040MSS  
Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices: AMA-MSS will ask the AMA to: (1) support improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices to: (a) make more stringent guidelines for which devices can qualify for the 510(k) exceptions; (b) mandate all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to market devices for the same clinical purpose; (2) support stronger pre-market assurance and post-market surveillance requirements of medical devices, including but not limited to (a): conditional approval of devices until sufficient post-market surveillance data determining device safety can be collected, followed by confirmatory trials, and (b) a publicly available summary of medical devices approved under expedited programs along with associated clinical trial data and list of reported adverse events; and (3) amend policy H-100.992 to include medical devices by addition as follows:

**FDA, H-100.992**

1. Our AMA reaffirms its support for the principles that:

(a) an FDA decision to approve a new drug or medical device, to withdraw a drug or medical device's approval, or to change the indications for use of a drug or medical device must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute;

(b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and

(c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug or medical device unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug or medical device is unsafe and/or ineffective for its labeled indications.

(MSS Res. 22, I-19) (MSS Res. 052, A-22, Substitute Resolution 052 be Adopted in Lieu of the Original) (Immediately forwarded to HOD, AMA Res. 523, Referred, A-22)
270.041MSS  
Supporting External Accountability for ICE and CBP: AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19) (Reaffirmed: MSS Res. 031, A-21)

270.042MSS  
Advocating for the Reimbursement of Remote Patient Monitoring for the Management of Chronic Conditions: Our AMA-MSS will ask the AMA to work with the Federation of State Medical Boards to draft model legislation to ensure remote patient monitoring is defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (MSS CHIT CEQM Rep. A, Nov. 2020)

270.043MSS  
Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices:
(1) Our AMA-MSS will ask the AMA to support the principles that: (a) confirmatory trials should be conducted in a timely fashion following accelerated approval of medical devices that are approved based on surrogate endpoints or limited evidence; and (b) the FDA should make the annual summary of medical devices approved under expedited programs more readily available to the public and consider adding information on confirmatory clinical trials and all reported adverse events for such medical devices.

(2) Our AMA-MSS will ask the AMA to amend policy H-100.992 by addition and deletion as follows:

FDA, H-100.992
1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug or medical device, to withdraw a drug or medical device's approval, or to change the indications for use of a drug or medical device must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or post market incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug or medical device unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and post market reports shows that the drug or medical device is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA’s decision-making process in the course of FDA
devising either general or product specific drug regulation.

3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

(MSS CSI CHIT Rep. A, Nov. 2020)

Re-Evaluating the FDA’s Citizen Petition Process: AMA-MSS will ask the AMA to work with relevant stakeholders to advocate for further public transparency of citizen petitions to the Food and Drug Administration (FDA), including the relationship between citizen petitions and decisions to delay generic approval, conflicts of interest to be disclosed, and the time and resources expended on petition reviews.

(MSS Res. 08, I-21)
Amending Policy on a Public Option to Maximize AMA Advocacy: AMA-MSS will ask the AMA to amend Policy H-165.823, “Options to Maximize Coverage under the AMA Proposal for Reform,” by addition and deletion as follows:

H-165.823 – OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM

1. Our AMA will advocate that any for a public option to expand health insurance coverage must that meets the following standards:
   a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
   b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
   c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
   d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
   e. The public option is financially self-sustaining and has uniform solvency requirements.
   f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
   g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

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

(MSS Res. 20, I-21)

270.046MSS  Support for Democracy: AMA-MSS will ask the AMA to: (1) unequivocally support the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans; (2) strongly oppose attempts to subvert the democratic process; and (3) assert that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it.

AMA-MSS will oppose political endorsements of and donations to candidates who attempt to subvert democratic election results.

(MSS Res. 63, I-21) (AMA Res. 433, Adopted [], A-22)

270.047MSS  Supporting Intimate Partner and Sexual Violence Safe Leave: AMA will ask the AMA to (1) recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave and (2) amend the existing policy H-420.979 AMA Statement on Family and Medical Leave to promote inclusivity by addition as follows:

AMA Statement on Family and Medical Leave, H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions and/or concerns for safety. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; (4) leave for adoption or for foster care leading to adoption; and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

(MSS Res. 005, A-22)
Expanding Employee Leave to Include Miscarriage and Stillbirth: AMA-MSS will ask (1) that our AMA amends Policy H-405.960, “Policies for Parental, Family, and Medical Necessity Leave”:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And (2) that our AMA amends H-420.979 “AMA Statement on Family and Medical Leave” due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, as follows:

**AMA Statement on Family and Medical Leave H-420.979**

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

(MSS Res. 011, A-22)
Policies for Parental, Family and Medical Necessity Leave, H-405.960

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(MSS WIM CME Report A, A-22)

Promotion and Support of Physician, Student, and Patient Participation in Government: AMA-MSS (1) recognize voting as a dimension of public health; and (2) formally support non-partisan voter registration in healthcare settings, including efforts to identify and aid patients who require additional assistance to vote in national elections.

(MSS COLRP COLA Rep A, A-22)

Licensure and Discipline

Competence for Licensure: AMA-MSS will ask the AMA to: (1) urge state licensing authorities to continue to recognize the NBME certificate; (2) recommend that medical school faculties continue to exercise responsibilities for evaluating students and house-staff; (3) oppose a licensing examination as a requirement for graduates of educational programs accredited by the LCME to enter the first year of graduate training; (4) oppose requirements for licensure requiring a long period of graduate education with the attendant risk of licensure by specialty; and (5) support a single FLEX examination sequence, during or shortly after the first year of graduate medical education. (MSS statement on MSS Res 12, I-81 Recommended amendments to CME Rep B, I-81 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
Interns' Qualifications: AMA-MSS (1) endorses the concept that an MD degree by an accredited U.S. medical school is a sufficient qualification for the intern to administer medical care as a member of the house-staff treatment team; and (2) opposes any attempts to impose additional requirements (e.g., FLEX I) in order to function as an intern. (MSS Res 11, I-81) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Use of Licensing Examination Scores: AMA-MSS supports AAMC efforts to urge the National Board of Medical Examiners to issue only pass-fail results of the National

275.009MSS Voting Rights For AMA-MSS NBME Representatives: (1) AMA-MSS will ask the AMA to: (a) petition the NBME to add AMA student representation to the National Board, the governing and voting body of the NBME; (b) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (2) The AMA-MSS Governing Council will pursue avenues to obtain AMA-MSS representation on the NBME Board. (MSS Amended Sub Res 10, I-98) (AMA Res 323, I-98 Adopted [H-295.893]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13) (Reaffirmed: MSS GC Rep A, I-19)

275.012MSS Support A Study on the Minimum Competencies and Scope of Medical Scribe Utilization: AMA-MSS will ask that our AMA partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of medical scribe utilization. (MSS Res 28, A-16) (Reaffirmed: MSS GC Report A, I-21)

275.013MSS Equality for COMLEX and USMLE: AMA-MSS will ask the AMA to (1) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (2) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (3) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (MSS Res 38, A-18)

275.014MSS Standardization of Medical Licensing Time Limits Across States: AMA-MSS will ask the AMA to amend H-275.978 Medical Licensure by addition as follows:

Medical Licensure H-275.978

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome, and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. 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;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10-1-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.
(MSS Res 48, I-17) (AMA Res 305, A-18, Referred)

275.015MSS Medical Licenses for Individuals with DACA Status: AMA-MSS will ask the AMA to 1) support the ability of Deferred Action for Childhood Arrivals (DACA) recipients to obtain medical licenses and 2) encourage state medical societies to consider a position of support for these individuals to obtain medical licenses in their respective states. (MSS Res. 02, I-19)

280.000MSS Long-Term Care


285.000MSS Managed Care


290.000MSS Medicaid

290.002MSS Interstate Medicaid Cooperation: AMA-MSS will ask the AMA to (1) support and advocate for legislation allowing out-of-state providers in close proximity to the border to be enrolled as in-state providers in those states that do not currently allow it, using Oregon’s Medicaid system as a model; and (2) support and advocate for legislation that would streamline the provider enrollment process in order to encourage more physicians to become providers for border communities. (MSS Res 28, I-10) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 113, A-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)
Opposition to Medicaid Work Requirements: AMA-MSS will ask that our AMA oppose work requirements as a criterion for Medicaid eligibility. (MSS Res 29, A-17)

Medicaid Coverage of Fitness Facility Memberships: AMA-MSS will ask the AMA to support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for low-income adult patients. (MSS Res 59, I-17) (AMA Res 109, A-18, Not Adopted)

Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes: Our AMA-MSS will ask the AMA to amend policy H-330.885, to include the following:

**MEDICARE PUBLIC INSURANCE COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES, H-330.885**

Our AMA supports efforts to achieve Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes by all public insurance programs.

(MSS Res. 014, Nov. 2020)

Expanding Medicaid Transportation to Include Health Grocery Destinations: Our AMA-MSS will ask the AMA to: (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) support inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations.

(MSS Res. 020, Nov. 2020) (AMA Res. 117, Alternate Resolution Adopted in Lieu [], A-22)

Health Coverage during States of Emergency: Our AMA-MSS supports increases in states’ Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue servicing Medicaid patients and cover rising enrollment.

(MSS Res. 038, Nov. 2020)

Federal Health Insurance Funding for People Experiencing Incarceration: (1) Our AMA-MSS will ask the AMA to advocate 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.

(2) Our AMA-MSS will ask the AMA to amend policy H-430.986 by addition and deletion as follows:

**HEALTH CARE WHILE INCARCERATED, H- 430.986**
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 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. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.

6. Our AMA encourages states not to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

7. Our AMA urges Congress, 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.

8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

9. The AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates 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.

(MSS Res. 076, Nov. 2020)

290.009MSS Establishing Comprehensive Dental Benefits Under State Medicaid Programs: AMA-MSS will ask the AMA to amend Policy H-330.872, “Medicare Coverage for Dental Services” by addition and deletion as follows:
Medicare, Medicaid, and Other Public Health Insurance Coverage for Dental Services, H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, Medicaid, and other public health insurance program beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among Medicare, Medicaid, and other public health insurance program beneficiaries populations, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease among Medicare, Medicaid, and other public health insurance programs beneficiaries populations, and the impact of expanded dental coverage on health care costs and utilization.

(MSS Res. 026, A-21)

290.010MSS Support for Vision Screenings and Visual Aids for Adults Covered by Medicaid: AMA-MSS will ask the AMA to advocate that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and any new public insurance programs.
(MSS CEQM CGPH Rep. A, I-21)

295.000MSS Medical Education


295.005MSS Availability of Medical Education: AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service- obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools. (MSS Position Paper 2, A-83) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 19, I-17)


295.011MSS  Regulation of Medical Student Education Opportunities: AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME standard for accreditation of undergraduate medical education programs and to oppose legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (AMA Res 142, I-87 Adopted [H-295.974]) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.012MSS  Promotion of Infection Control Procedures in the Medical School Setting: AMA-MSS will ask the AMA to: (1) encourage training in infection control to occur throughout the medical school curriculum; (2) urge teaching hospitals to be equipped with the necessary supplies to comply with the Center for Disease Control infection control recommendations; and (3) urge medical schools to integrate a student's use of proper infection control techniques in the student's evaluations. (MSS Rep G, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

295.018MSS  Addition of Instruction on Organ and Tissue Procurement to the Medical Student Curriculum: AMA-MSS will ask the AMA to encourage the Liaison Committee on Medical Education (LCME) to recommend incorporation into medical schools' curricula content focusing on organ and tissue procurement. (MSS Sub Res 4, I-89) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


295.027MSS  Adequate Insurance for Medical Students and Residents: AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (AMA Res 252, A-91 Referred) (BOT Rep W, I-91 Adopted [H-295.942]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed:

295.029MSS Medical Student Legislative Awareness: AMA-MSS will recommend that: (1) medical students actively encourage state medical societies to sponsor legislative awareness workshops for students and that MSS chapters should establish a dialogue between medical society legislative personnel; and (2) all medical students register to vote, keep abreast of legislators' positions on issues that affect physicians, and actively contact legislators for their support of such issues. (COLRP Rep A, A-91) (AMA Res 14, A-91 Adopted [H-295.953]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


295.035MSS Medical School Waiting Lists: AMA-MSS recommends that prospective medical students keep medical schools informed about their decision-making process with respect to acceptances, including turning back acceptances to medical schools as soon as a decision not to attend has been made. (MSS Rep F, A-92) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)


295.054MSS Commonwealth Puerto Rican as a Minority Group: AMA-MSS will ask the AMA to recognize all Puerto Ricans, regardless of place of residence (Commonwealth or mainland), as an underrepresented minority when applying to mainland medical schools and convey this policy to the Association of American Medical Colleges and other bodies as appropriate. (MSS Rep C, I-94) (AMA Res 313, A-95 Referred) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.057MSS Child Care Resource Information for Medical Students: AMA-MSS will advocate the provision of child care resources at medical schools, including the availability of on-site child care (day and night) as well as information regarding subsidies for child care and information on child care alternatives for those parents who do not use the on-site services or whose institution is unable to accommodate such services. (MSS Amended Sub Res 22, I-94) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


295.066MSS Medical Student Impairment Policies: AMA-MSS will ask the AMA to: (1) strongly encourage medical schools that have not yet established policy on medical student impairment and implemented programs to prevent and treat student impairment to do so immediately; and (2) stress to medical schools the importance of increased information and visibility of medical student impairment policy and programs for the student body and that resources should be made readily available to the students throughout medical school and reiterated at the beginning of each year. (AMA Res 303, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.067MSS Medical Education about Sexual Assault: AMA-MSS will ask the AMA to encourage medical schools to incorporate information about rape exam procedures, the rape trauma syndrome, the psychological needs of survivors of sexual assault, and available rape support groups into their clinical preparation curriculum. (AMA Amended Res 301, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

295.068MSS Medical School and Occupational Exposure: AMA-MSS encourages institutions to continually educate their students on occupational exposure protocols and encourage medical students to become well-informed and aware of the relevant procedures


295.081MSS  Promoting Culturally Competent Health Care: AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with

295.082MSS Respect for Individual Student’s Beliefs: AMA-MSS will ask the AMA to encourage medical schools to adopt a policy whereby medical students would be allowed, without penalty, to withdraw from participating in medical procedures that may be violative of personally held moral principles or religious beliefs, provided that the students receive a satisfactory knowledge of the principles associated with the procedure and that the medical schools establish their own guidelines concerning specific procedures and situations in order to avoid the potential of abuse. (MSS Sub Res 7, I-96) (AMA Res 304, A-97 Referred) (CME Rep 4, A-98 Adopted in Lieu of Res 304 [H-295.896]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


295.101MSS Support for the Accreditation of US Medical Schools: AMA-MSS recommends that as new medical schools are established in the US, they should be encouraged to apply for LCME or AOA accreditation. (2) AMA-MSS will join efforts to educate the public, physicians, health policy leaders, educators, and elected officials about the need to maintain quality standards in medical education. (3) AMA-MSS will encourage and will ask the AMA to encourage efforts to educate all prospective

295.104MSS Privacy and Confidentiality of Medical Students in Physical Diagnosis Classes: AMA-MSS supports the protection of medical student privacy and confidentiality in the context of physical diagnosis classes by adopting the following principles: (1) If abnormal physical findings are found on a student during a physical diagnosis class, the student should not be used as a model of abnormal findings without their explicit, meaningful, and non-coerced consent; (2) No information regarding abnormal physical findings encountered on a medical student during a physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent. (MSS Late Res 1, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

295.110MSS US Medical Student Match Fees: AMA-MSS strongly encourages the NRMP staff to continue an equitable NRMP Match fee structure for both U.S. Medical Students and Independent Applicants that appropriately reflects actual costs for each group. (MSS Sub Late Res 1, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

295.111MSS State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam: AMA-MSS will ask the AMA to: (a) commend the LCME for making clinical skill competencies a priority, (b) work with the AAMC and LCME to assure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum, and (c) encourage all LCME accredited medical schools to adopt as policy that all medical students at their institutions pass an OSCE or CSAE as part of the matriculation requirements for the conferring of an MD degree. (MSS Late Res 1, A-02) (AMA Sub Res 308, A-02, Adopted [D-295.968]) (Amended: MSS Rep C, I-07) (D-295.968 Rescinded: CCB/CLRPD Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.114MSS Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation: (1) AMA-MSS will ask the AMA to: (a) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam (USMLE) Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME); (b) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE; (c) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first 5 years of the implementation of the exam; (d) encourage medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (e) study, in conjunction with the NRMP,
AOA, AGCME, and other interested organizations, the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education; (f) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 4 months; and (g) monitor in an ongoing fashion, the implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum. (2) AMA-MSS will study safeguard measures for students in the first five years of implementation of the Clinical Skills Assessment Exam and COMLEX-PE; (MSS Res 7, A-03) (AMA Amended Res 324, A-03 Adopted in lieu of Resolution 315 [D-275.985]) (Amended: MSS Rep E, I-08) (D-275.985 Rescinded: CME Rep. 2, A-13) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)


295.116MSS Opposition to Clinical Skills Examinations for Physician Medical Re-Licensure: AMA-MSS will ask the AMA to: (1) oppose clinical skills examinations for the purpose of physician medical re-licensure until such examinations can be shown to accurately predict physician clinical incompetence or moral turpitude; (2) reaffirm its support for continuous quality improvement of practicing physicians; and (3) support research into methods to improve clinical practice, including practice guidelines and continue to support the implementation of quality improvement through local professional, non-governmental oversight. (MSS Res 13, I-03) (AMA Amended Res 307, A-04 Adopted in lieu of AMA Res 313 [H-275.930]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

295.117MSS Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam: AMA-MSS will ask the AMA to oppose additions to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam that lack predictive validity for future performance as a physician and work with appropriate organizations toward requiring consensus approval by professional medical organizations for implementation of additions or modifications to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam. (MSS Res 14, I-03) (AMA Amended Res 308, A-04 Adopted [H-275.929]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

295.119MSS State Support of Public Medical School Education: AMA-MSS will ask the AMA to oppose any legislation that would compel graduates of public medical schools to agree to practice in a particular locale upon completion of medical training, including a medical residency, as a condition of matriculation. (MSS Res 1, A-04) (AMA Amended Res 708, I-04 [H-305.931]) (Reaffirmed: MSS GC Report B, I-09) (H-
Modernization of Medical Education Assessment and Medical School Accreditation: AMA-MSS will ask the AMA to: (1) vigorously work to establish medical education system reforms throughout the medical education continuum that demand evidence-based teaching methods that positively impact patient safety or quality of patient care; and (2) work with the Liaison Committee on Medical Education (LCME) to perform frequent and extensive educational outcomes assessment of specialized competencies in the medical school accreditation process at minimum every four years, requiring evidence showing the degree to which educational objectives impacting patient safety or quality of patient care are or are not being attained. (MSS Res 9, A-04) (AMA Res 818, I-04 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS Resolution 01, A-19)

Teaching and Evaluating Professionalism in Medical Schools: AMA-MSS will ask the AMA to: (1) strongly urge the Liaison Committee on Medical Education to promptly create and enforce uniform accreditation standards that require all LCME-accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the Liaison Committee on Medical Education to develop competencies for professional behavior and a mechanism for outcome assessment at least every four years in the accreditation process, examining teaching and evaluation of the competencies at LCME-accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for licensure of graduates of LCME-accredited medical schools; continue its efforts to teach and evaluate professionalism during medical education; and (4) actively oppose, by all available means, any attempt by the NBME and/or FSMB to add separate, fee-based examinations of behaviors of professionalism to the United States Licensing Examinations. (MSS Res 10, A-04) (AMA Amended Res 304, A-05 Adopted [D-295.954]) (Reaffirmed: MSS GC Report B, I-09) (D-295.954 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Medical Student Clinical Training and Education Conditions: AMA-MSS will ask the AMA to: (1) commend the LCME for addressing the issue of the medical student learning environment including student clerkship hours; (2) urge the LCME to adopt specific medical student clinical training and educational guidelines for the clerkship years including: (a) No more than one night on call every three nights; (b) No more than 80 hours total of clinical training and education time per week averaged over four weeks; and (c) No more than 24 consecutive hours on call; and (2) recommend that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision. (MSS Res 16, I-03 Referred) (AMA Res 310, A-04 Referred) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Improving Sexual Education in the Medical School Curriculum: AMA-MSS will ask the AMA to: (1) encourage all medical schools to train medical students to be able to take a thorough and non-judgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) issue a public service announcement that encourages patients to discuss concerns related to sexual health

295.130MSS Educating Medical Students about the Pharmaceutical Industry: AMA-MSS will ask the AMA to: (1) strongly encourage medical schools to include unbiased curricula concerning the impact of direct-to-consumer marketing practice employed by the pharmaceutical industry, as they relate to the physician-patient relationship; and (2) strongly encourage medical schools to include unbiased information in their curricula concerning the pharmaceutical industry regarding (a) the cost of research and development for new medications, (b) the cost of promoting and advertising new medications, and (c) the proportion of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision-making process involved in prescribing medications specifically using evidence-based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class. (MSS Sub Res 15, I-04) (AMA Res 303, A-05 Adopted [D-295.955]) (Modified: MSS GC Report B, I-09) (D-295.955 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

295.131MSS Equal Fees for Osteopathic and Allopathic Medical Students: AMA-MSS will ask the AMA to: (1) reaffirm AMA Policies H-405.989 and G-635.053; (2) discourage discrimination by institutions and programs based on Osteopathic or Allopathic training; (3) support equal fees for clinical rotation externships by Osteopathic and Allopathic medical students; and (4) encourage that LCME/ACGME accredited institutions maintain fair practice standards for equal access to all US medical students, Osteopathic and Allopathic (MSS Amended Res 3, A-05) (AMA Res 809, I-05 R1 Adopted, R2 Adopted as Amended, R3 and R4 Referred [H-295.876]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


295.133MSS Instruction of Effective Teaching Methods in Medical School Curricula: AMA-MSS will encourage the Liaison Committee on Medical Education to recommend that medical schools include instruction on effective teaching methods in their curricula. (MSS Res 8, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.134MSS Relocation of Medical Students in the Event of Emergency: AMA-MSS supports the formation of protocols by individual medical schools to relocate and temporarily or permanently assimilate medical students into other medical schools in the event of a crisis or natural disaster resulting in the closing of their medical school. (MSS Res 9, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.136MSS  Combining the AOA and ACGME Resident Matching Programs: AMA-MSS will request that the NRMP explore the possibility of combining the AOA and the NRMP match and that the AMA-MSS await the report of the American Osteopathic Association House of Delegates on combining the AOA and NRMP match programs and continue to monitor the final actions of the various osteopathic governing bodies. (MSS Rep A, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.137MSS  Expansion of Student Health Services: AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center’s hours to include weekend coverage. (MSS Rep D, I-05, AMA Res 309, A-06, Referred) (CME Rep 6, A-07 Adopted [H-295.956]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


295.139MSS  Standardization of Medical Student Background Checks: AMA-MSS (1) will collaborate with the appropriate organizations to ensure the standardization of medical student criminal background checks throughout all LCME and AOA accredited medical schools; and (2) will work with the appropriate organizations to ensure that medical student criminal background checks are structured to maintain the student’s confidentiality, as well as avoid excessive frequency, cost, and duplicity as students rotate through clinical sites. (MSS Res 4, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


295.141MSS  Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students: (1) AMA-MSS will ask the AMA to recognize that inter-professional education and partnerships are a top priority of the American medical education system; (2) AMA-MSS will ask the AMA to explore the feasibility of the implementation of LCME and AOA accreditation standards requiring inter-professional training in medical schools. (MSS GC Report A, A-07) (AMA Res 308,

295.142MSS Communication and Clinical Teaching Curricula: (1) AMA-MSS (a) supports the development of formalized medical teacher training for residents and attending faculty and (b) will ask the AMA to establish policy supporting the development of formalized medical teacher training for residents and attending faculty. (MS GC Report B, A-07) (AMA Res 804 Referred) (Modified: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.144MSS Support for Family and Relationships During Medical School and Residency: (1) AMA-MSS will work with the RFS, the AMA Alliance, and other interested organizations to (a) urge medical schools and residency programs to provide access to and encourage use of relationship counseling; (b) encourage medical schools and residency programs to offer workshops, activities, or lectures regarding the balance of family life with medical training and practice; and (c) promote opportunities for student and resident spouses and partners to become involved in the medical community, particularly through the AMA Alliance. (MSS Amended Res 13, I-07) (Modified: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.145MSS One Health: AMA-MSS will engage in dialog with the Student American Veterinary Medical Association to promote collaboration with the public health and veterinary professional and educational communities. (MSS Res 12, A-08) (Modified: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

295.147MSS Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year: AMA-MSS will ask the AMA to (1) strongly encourage the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA) accredited medical schools; (2) support and encourage the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school; (3) encourage the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation, continue to have a mechanism for accepting such applications of osteopathic medical students; and (4) explore the feasibility of collaborating with other stakeholder organizations and funding agencies to convene leaders in allopathic and osteopathic medicine responsible for undergraduate and graduate medical education, accreditation and certification, to explore opportunities to align education policies and practices, including visiting student elective opportunities. (MSS Amended Res 2, A-09) (AMA Res 910, I-09 [H-295.867]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

295.150MSS  USMLE and COMLEX Exam Fee Burden: AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students. (MSS Res 4, A-10) (Reaffirmed, MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

295.151MSS  Including Elements of the Patient-Centered Medical Home Model in Medical Education: AMA-MSS encourages medical schools and residency programs to incorporate elements of the patient-centered medical home model, as defined by the AMA’s Joint Principles of the Patient Centered Medical Home, into medical education. (MSS Res 7, A-10) (Reaffirmed MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.152MSS  Medical Student Access to Electronic Medical Records: AMA-MSS will ask the AMA to encourage teaching hospitals and other clinical clerkship sites to allow medical student access to patient electronic medical records. (MSS Res 8, A-10) (AMA Amended Res 5, I-10 Adopted [D-315.979]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


295.154MSS  Encouraging the Inclusion of Preclinical Longitudinal Clinical Experiences in the Medical Education Curriculum: AMA-MSS will ask the AMA to encourage medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education. (MSS Res 6, I-10) (AMA Res 309, A-11 Adopted [D-295.960]) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.155MSS  Global Health Education: AMA-MSS will ask the AMA to (1) recognize the importance of global health education for medical students; and (2) encourage medical schools to include global health learning opportunities in their medical education curricula. (MSS Res 9, I-10) (AMA Res 310 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

295.156MSS  Medical School International Service Learning Opportunities: AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical school international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences; and (2) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities. (MSS Res 13, I-10) (AMA Res 307 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
Encouraging Medical Student Professionalism: Affirming Institutional Financial Disclosure Policies During Undergraduate Medical Education: AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to encourage the Liaison Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure database(s) that exist as required by the Patient Protection and Affordable Care Act (H.R. 3590 Section 6002); and (2) work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (MSS Res 16, I-10) (Reaffirmed: MSS Res 11, A-11) (AMA Res 308, A-11 Adopted [D-140.981]) (Modified and Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Access to Vaccinations for Student and Healthcare Workers: AMA-MSS recommends (1) That all medical schools provide all institutionally required vaccinations to health professions students, with implementation costs to be part of student fees, unless medically contraindicated; and (2) That hospitals provide necessary access to vaccinations for their healthcare personnel. (MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment: AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan. (MSS Res 3, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


Expanding Clerkship Site Access to Include U.S. Medical Schools Undergoing Accreditation: AMA-MSS will ask the AMA to amend Policy D-295.320 by insertion as follows:

D-295.320 Factors Affecting the Availability of Clinical Training Sites for Medical Student Education

Our American Medical Association will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for
2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.


295.167MSS Quality Improvement Education in Medical Schools and Residency Programs: AMA-MSS will (1) advocate to medical school deans for the inclusion of quality improvement education in medical school curricula; (2) encourage the American College of Medical Quality, the Association of American Medical Colleges, the Liaison Committee on Medical Education, the American Association of Colleges of Osteopathic Medicine, the Commission on Osteopathic Colleges Accreditation, and other relevant bodies to develop a basic set of core competencies in medical quality improvement that all medical school curricula should include; (3) encourage the American College of Medical Quality and other appropriate organizations to develop a guideline curriculum in medical quality improvement to be made available to medical schools; and (4) work with relevant parties to monitor the national implementation of quality improvement education in medical school curricula and report back to the Medical Student Section. (MSS Res 4, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.168MSS Expansion of Medical Spanish in US Medical Schools: AMA-MSS will encourage the AAMC, LCME, COCA, and AOA to identify and evaluate existing ways that schools incorporate medical Spanish and other non-English languages into their curricula and report successful strategies for improved proficiency to be used as guidelines for US accredited medical schools. (MSS Res 6, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.169MSS Eliminating Legacy Admissions: AMA-MSS will ask the AMA to oppose the use of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging the AAMC, AACOM, LCME, and the AACOM to remove any questions on secondary applications pertaining to legacy status. (MSS Res 8, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.170MSS Supporting Two-Interval Grading Systems for Medical Education: AMA-MSS acknowledges the benefits of a two-interval grading system in medical colleges and universities for the non-clinical curriculum. (MSS Late Res 2, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.171MSS Health Policy Education in Medical Schools: (1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based
development of behavioral and social science foundations for medical students; and (2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies. (GC Rep B, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.172MSS Insurance Education for Medical Students: AMA-MSS will ask the AMA to work with the AAMC, AACOM, LCME, and COCA to encourage integration of medical educational curricula on insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid, and the physician’s role in obtaining affordable care for patients. (MSS Res 5, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.173MSS Policy and Advocacy Rotations for Medical Students: AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and (2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies. (MSS Res 6, I-12) (Sub AMA Res 301, A-13 Adopted [H-295.864]) (Reaffirmed: MSS GC Report A, I-17)

295.174MSS Evaluation of Standardized Clinical Skills Exams: AMA-MSS will ask the AMA to (1) evaluate the benefits and consequences of the implementation of the standardized clinical skills exams as a step for licensure and provide recommendations based on these findings; and (2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills Exam and their implications for US medical students. (MSS Res 7, A-13) (AMA Res 904, I-13 Adopted [D-295.960]) (Reaffirmed: MSS GC Rep A, I-19)

295.175MSS Medical Student Mistreatment: AMA-MSS will encourage medical schools to have procedures in place for students to report incidents of mistreatment without fear of retaliation and that instructions on how to report incidents should be explained to students at the beginning of medical school and again before starting rotations. (MSS Res 3, I-13) (Reaffirmed: MSS GC Rep A, I-19)


295.177MSS Shared Decision-Making in Medical Education: AMA-MSS will ask the AMA to (1) amend policy D.373.999 by insertion as follows:

D-373.999 Informed Patient Choice and Shared Decision Making

(1) Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical
community in moving towards patient-centered care; and

(2) Collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids.


295.178MSS  Motivational Interviewing in Medical Education: AMA-MSS supports the incorporation of motivational interviewing into medical school curriculum.


295.179MSS  AMA Support for Increasing Access to Shadowing Opportunities for Premedical Students: AMA-MSS encourages state medical societies to create a database of physicians willing to provide shadowing opportunities to undergraduate students. (MSS Res 37, A-14) (Reaffirmed: MSS GC Rep A, I-19)

295.180MSS  Promoting Education of Electronic Health Records in Undergraduate Medical Education: AMA-MSS will ask the AMA to support efforts to incorporate electronic health records training into undergraduate medical education. (MSS Res 7, A-14) (AMA Res 907, I-14 Referred) (Reaffirmed: MSS GC Rep A, I-19)

295.181MSS  Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum: AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations. (MSS Res 12, A-14) (AMA Res 908, I-14 Adopted as Amended [H-295.874]) (Reaffirmed: MSS GC Rep A, I-19)

295.182MSS  USMLE Step 1 Timing: AMA-MSS will ask the AMA to ask the NBME to track USMLE Step 1 exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 exam performance. (MSS Res 20, A-14) (AMA Res 911, I-14 Adopted as Amended [D-275.958]) (Reaffirmed: MSS GC Rep A, I-19)

295.183MSS  Combating Sex-Linked Discrimination of Denying Special Request for Lactation during Medical Board Examination: AMA-MSS will ask the AMA to: (1) urge all medical examination agencies to grant special request to give breast feeding test-takers additional break time and a suitable environment during the medical licensing examination to express milk; and (2) encourage all medical examination agencies to serve as role models to improve public health by supporting mothers who provide breast milk to their infants. (MSS Res 42, A-14) (Substitute AMA Res 903, I-14 Adopted with Change in Title [H-295.861]) (Reaffirmed: MSS GC Rep A, I-19)

295.184MSS  Medical Student Involvement in Handoffs: AMA-MSS (1) recognizes the importance of medical student involvement in patient handoffs as integral to
both comprehensive medical education and quality patient care; and (2) encourages supervised medical student involvement in patient handoffs. (MSS Res 9, I-14) (Amended and Reaffirmed: MSS GC Rep A, I-19)

295.185MSS Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages: AMA-MSS will ask that the AMA study the issue of Deferred Action for Childhood Arrivals (DACA)-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. (MSS Late Res 4, I-14) (Reaffirmed: MSS GC Rep A, I-19)


295.187MSS Promoting and Reaffirming Domestic Medical School Clerkship Education: AMA-MSS will ask (1) that our AMA pursue avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; (2) that our AMA support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and (3) that our AMA reaffirm policies D-295.320, D-295.931, and D-295.937. (MSS Res 18, A-16) (Reaffirmed: MSS GC Report A, I-21)

295.188MSS Future of the United States Medical Licensing Examination (USMLE): Examining Multi-Step Structure and Score Usage: AMA-MSS will ask that our AMA (1) work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 Clinical Knowledge (CK) exams into a single licensure exam measuring both foundational science and clinical knowledge competencies, and (2) work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams. (MSS Res 21, I-16) (AMA Res 309, A-17 Adopted as Amended [appended to H-275.962 and H-275.953]) (Reaffirmed: MSS GC Report A, I-21)

295.190MSS Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are LGBTQ+: Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic

295.191MSS Educating Physicians About the Importance of Cervical Cancer Screening for Transgender Men Patients: AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows:

**Healthcare Needs of LGBTQ+ Lesbian Gay Bisexual and Transgender Populations H-160.991**

Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women transgender men when medically indicated to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk of sexually transmitted diseases.


295.192MSS Medical Student Involvement and Validation of the Standardized Video Interview Implementation: AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and its partners to assure that medical students and residents are recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and (2) advocate for delaying expansion of the Standardized Video Interview until published data demonstrates the efficacy and utility of the Standardized Video Interview as a mandatory residency application requirement. (MSS Res 16, I-17)

295.193MSS Implicit Bias and Its Effects on healthcare and Its Incorporation into Undergraduate Medical Education: AMA-MSS (1) recognizes the existence of implicit bias among health care clinicians; (2) recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and (3) supports medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients. (MSS Res 07, I-17)

295.194MSS Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum: AMA-MSS (1) recognizes that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; and (2) supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation. (MSS Res 74-I-17)

295.195MSS Introducing Teach-back Education into Medical School Curriculum: AMA- MSS supports the training of the teach-back technique in medical schools. (MSS Res 34, I-18)
295.196MSS  Increasing Access to Trauma-Informed Services within Schools: AMA-MSS will ask the AMA to (1) encourage physicians, residents and medical students to utilize current integrated care approaches that engage school-based trauma informed services; and (2) encourage stakeholders to implement trauma-informed school-based services. (MSS Res 35 I-18) (AMA Res 504, A-19, Combined with Res 526 and Adopted [H-515.952])

295.197MSS  Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools: AMA-MSS will ask the AMA to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved. (MSS Res 37 I-18) (AMA Res 322, A-19, Adopted as amended and with Title Change [H-295.856])

295.198MSS  Engaging Stakeholders for Establishment of Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools: AMA-MSS will ask the AMA to amend policy H-295.866 as follows:

Supporting Two-Interval Grading Systems for Medical Education H-295.866

Our AMA will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum. (MSS Res 13, A-19) (AMA Res. 301, Adopt [H-295.866], I-19)

295.199MSS  Strengthening Standards for LGBTQ Medical Education: AMA-MSS will ask the AMA to amend policy H-295.878, Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education by insertion and deletion to read as follows:

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency curriculum curricula for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and
Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of Lesbian, Gay, Bisexual, Transgender and Queer patients.

(MSS Res 16, A-19) (AMA Res. 302, Adopt as Amended [H-295.878], I-19)

295.200MSS Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations: AMA-MSS will ask the AMA to work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and general a report with the findings by I-20. (MSS Res 45, A-19) (AMA Res. 303, Adopt [H-295.876], I-19)

295.201MSS Standard Procedure for Accommodations in USMLE and NBME Exams: AMA-MSS will ask the AMA to: (1) collaborate with medical licensing organizations to facilitate a timely accommodations application process; and (2) in conjunction with the National Board of Medical Examiners, develop a plan to reduce the among of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (MSS Res. 11, I-19)

295.202MSS Studying an Application Cap for the National Residency Match Program: AMA-MSS will study the implementation of application limits for the National Residency Match Program (NRMP) through the Electronic Residency Application Services (ERAS) as a means of addressing the increase in residency application volume on individual residency programs. (MSS Res. 15, I-19)

295.203MSS Supporting the INCUS Report Recommendations to Explore Further Research into Possible Changes to the USMLE Step 1 Scoring System: AMA-MSS (1) supports efforts to minimize racial demographic differences that exist in USMLE performance; and (2) supports efforts to convene a cross- organizational panel to create solutions for challenges in the UME-GME transition. (MSS Res. 33, I-19)

295.204MSS Evaluating the Use of Third-Party Resources in Medical Education: AMA-MSS supports the augmentation of traditional medical curricula with third- party, non- institutional resources, as well as continued research into innovative methods of incorporating these resources into medical education curricula. (MSS Res. 35, I-19)

295.205MSS Report and Recommendations on the Residency Application Process: AMA-MSS will ask the AMA to collaborate with appropriate stakeholders to study existing communication practices during the residency application process and provide recommendations to improve communications throughout this process. (MSS Res. 38, I-19)

295.206MSS Protecting Medical Student Access to Abortion Education and Training: AMA-MSS will ask the AMA to amend policy H-295.923, Medical Training and Termination of Pregnancy by insertion and deletion as follows:
H-295.923 – Medical Training and Termination of Pregnancy
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Although observation of, attendance at, or any direct or indirect participation in abortion procedures should not be required, AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee of Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists’ recommendations.


295.207MSS Family Planning for Medical Students: AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and (3) supports medical schools providing six weeks of parental leave for medical students of all genders, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and (4) encourages medical schools to make these formal policies easily accessible for both current and prospective students. (MSS Res. 51, I-19) (Amended MSS WIM Report A, A-21)

295.208MSS Buprenorphine Training in Medical Schools: AMA-MSS supports the standardized buprenorphine training addition in medical school curricula to reduce the patient-provider gap in prescribing medication assisted treatment to those with substance use disorder. (MSS Res. 54, I-19) (Reaffirmed: MSS Res. 120, Nov. 2020)

295.209MSS Addressing the Need for Firearm Safety in Medical School Curricula: AMA-MSS will ask the AMA to support the inclusion of gun violence epidemiology and evidence-based firearm-related injury prevention education in medical school curricula. (MSS Res. 63, I-19)

295.210MSS Requiring Blinded Review of Medical Student Performance: AMA-MSS will ask the AMA to work with appropriate stakeholders, such as the Liaison
Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) to support: (1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students’ performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students, and (2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring. (MSS CME Report A, I-19)

Improving Support and Access for Medical Students with Disabilities: AMA-MSS will ask the AMA to:
(1) Amend policy D-295.929 by addition as follows:

D-295.929 – A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees and students with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates and students with disabilities and challenges to employment after training and medical education; and (3) work with relative stakeholders to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms.

(2) Amend policy D-90.991 by addition and deletion as follows: D-90.991 – Advocacy for Physicians with Disabilities
1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians and medical students with disabilities including but not limited to: (a) enhancing representation of physicians and medical students with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians and medical students with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians and medical students with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians, and physicians-in-training, and medical student education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.
(MSS CME Report B, I-19)

Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Our AMA-MSS will ask the AMA to (1) encourage medical schools to accept flexible uses for excused absences from clinical clerkships; and (2) support a clearly defined number of easily accessible personal days for medical schools per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted
Supporting the Availability of Closed Caption in Medical Education: Our AMA-MSS will ask the AMA to collaborate with the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical school communications, including but not limited to, lecture recordings, videos, webinars, and audio recordings, that may prohibit any students from accessing information. (MSS Res. 001, Nov. 2020)

Identifying and Decreasing Barriers DACA-Eligible Medical Students Face in Applying to Medical School: Our AMA-MSS will work with appropriate stakeholders to identify and decrease barriers, including but not limited to those for undergraduate education and undergraduate medical education, faced by Deferred Action for Childhood Arrivals-eligible individuals who are applying to medical schools in the United States. (MSS Res. 037, Nov. 2020)

Supporting Medical Student Physician Shadowing in a Remote Capacity during the Current Crisis: Our AMA-MSS supports the use of telemedicine technologies for use by pre-medical and medical students for the purpose of physician shadowing. (MSS Res. 045, Nov. 2020)

Educate Residency, Fellowship, and Academic Programs on the United States – Puerto Rico Relationship Status: Our AMA-MSS will ask the AMA to (1) issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), American Association of Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited and their medical students are not considered international medical graduates and (2) support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools. (MSS Res. 057, Nov. 2020) (AMA Res. 305, I-21, Sub. Res Adopted in Lieu of [H-295.854])

Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education: Our AMA-MSS will research various approaches to grading of clinical clerkships, which may minimize racial bias in medical education. (MSS Res. 067, Nov. 2020)

Education in Communicating with and Providing Services to Individuals with Communication Disorders: Our AMA-MSS supports the development and implementation of medical student education that address the role and utility...
of rehabilitative healthcare providers in the treatment of individuals with communication disorders, including, but not limited to, speech-language pathologists and audiologists.
(MSS Res. 080, Nov. 2020)

295.219MSS Encouraging Residency Program Collaboration to Allow Medical Students Fair and Equitable Application Processes: Our AMA-MSS will ask the AMA to: (1) collaborate with the AAMC, AACOM, ACGME, and other relevant stakeholders to encourage the creation of equally accessible virtual away-rotation opportunities and networking events for medical students and residents, especially those who do not have home programs in their desired specialty; and (2) encourage residency programs to expand and regularly update information provided on their websites, including but not limited to residency research achievements, fellowship match information, operative/rotation schedules, and trends in post-residency practice settings.
(MSS Res. 091, Nov. 2020)

295.220MSS Sexual Harassment Accreditation Standards for Medical Training Programs: Our AMA-MSS will ask the AMA to: (1) encourage the LCME and ACGME to create a standard for accreditation that includes sexual harassment training, policies, and repercussions for sexual harassment in undergraduate and graduate medical programs; and (2) encourage the LCME and ACGME to assess: (a) medical trainees’ perception of institutional culture regarding sexual harassment and preventative trainings, and (b) sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource utilization in order to recommend best practices.
(MSS Res. 104, Nov. 2020) (AMA Res. 324, Adopted as Amended with Title Change []

295.221MSS Guaranteed Time Off on Election Days at Medical Schools: Our AMA-MSS will ask the AMA to work with appropriate stakeholders to guarantee a full day off on Election Days at Medical Schools.
(MSS Res. 112, Nov. 2020)

295.222MSS Support for Administration of USMLE and COMLEX Examinations by Home Institutions: Our AMA-MSS supports the continued exploration of a permanent shift in the administration of USMLE and COMLEX examinations away from third-party testing sites and toward primary administration of home institutions with the supplementation of third party testing sites to accommodate test takers incapable of testing at home institutions.
(MSS Res. 114, Nov. 2020)

295.223MSS Respecting Religious Diversity in Medical Education: Our AMA-MSS supports inclusive accommodation for students who feel restricted in their religious obligations in peer physical examination courses, including osteopathic manipulative medicine and clinical skills instruction.
(MSS Res. 122, Nov. 2020)

295.224MSS Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education: Our AMA-MSS will ask the AMA to amend policy D-155.988, Support for the Concepts of the “Choosing Wisely” Program by addition as follows:
SUPPORT FOR THE CONCEPTS OF THE “CHOOSING WISELY” PROGRAM, D-155.988
1. Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program. 2. Our AMA supports the inclusion of the evidence-based concepts of the American Board of Internal Medicine Foundation’s Choosing Wisely program in undergraduate and graduate medical education.
(MSS Res. 124, Nov. 2020)

295.225MSS Medical Honor Society Inequities and Reform: AMA-MSS will ask the AMA to (1) recognize that demographic and socioeconomic inequities exist in medical student membership in medical honor societies; and (2) study reforms to mitigate demographic and socioeconomic inequities in the selection of medical students for medical honor societies, including Alpha Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the selection of medical students to these societies on equity in the residency application process and report back by the November 2021 HOD meeting.
(MSS Res. 003, A-21)(Immediately Forwarded to HOD but not considered, A-21)

295.226MSS University Land Grant Status in Medical School Admissions:
(1) AMA-MSS will ask the AMA to work with the Association of American Medical Colleges (AAMC), Liaison Committee on Medical Education (LCME), Association of American Indian Physicians, and the Association of Native American Medical Students to design and promulgate medical school’s admissions recommendations in line with the federal trust responsibility
(2) AMA-MSS will ask the AMA to amend Policy H-350.981, AMA Support of American Indian Health Career Opportunities, by addition to read as follows:

AMA Support of American Indian Health Career Opportunities, H-350.981 AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded;
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities.

(MSS Res. 023, A-21) (AMA Res. 308, Referred for Decision, A-22)

295.227MSS Equitable Reporting of USMLE Step 1 Scores: AMA-MSS will ask the AMA to work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit USMLE Step 1 or COMLEX Level 1 scores and students who received Pass/Fail scores. (MSS Res. 036, A-21) (AMA Res. 301, I-21, Adopt as Amended with Title Change [H-275.953])

295.228MSS Recommending Allyship Training in Medical Education: AMA-MSS supports the inclusion of allyship trainings, which educate participants to use power and privilege to support individuals who experience oppression, in undergraduate, graduate, and continuing medical education. (MSS Res. 040, A-21)

295.229MSS Reporting of Program-Level Demographic Data to FREIDA: AMA-MSS study the topic of residency programs publishing and sharing with FREIDA demographic data, including but not limited to age, disability status, gender identity, Underrepresented in Medicine (URM) status, and LGBTQ+ status of their programs, as well as data on use of family planning policies in the residency program. (Sub. Res. 041, A-21)

295.230MSS Online Medical School Interview Option: AMA-MSS will ask the AMA to work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants including but not limited to financial implications and potential solutions, long term success, and well-being of students/residents. (MSS Res. 056, A-21)

295.231MSS Research the Ability of Two-Interval Grading of Clinical Clerkships to Minimize Racial Bias in Medical Education: AMA-MSS will ask the AMA to study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (MSS CME MIC Report A, A-21)
295.232MSS  Understanding Philanthropic Efforts to Address Rise of Medical School Tuition: AMA-MSS will study this topic every four years to gain a better understanding of the sustainability and impact of free and reduced medical tuition programs including, but not limited to, debt burden beyond medical school, effects of debt on medical specialty choice, as well as applicant diversity related to potential debt and release its findings in an informational report to the Assembly at A-25. (MSS COLRP CME Report A, A-21)

295.233MSS  Support for Family Planning for Medical Students: AMA-MSS continues to support family leave related policies brought forth by other delegations so as not to diminish incremental advancement in advocacy related to the topic. (MSS WIM Report A, A-21)

295.234MSS  Supporting Minimum Content Standards of LGBTQ+ Health Curriculum in Undergraduate Medical Education: AMA-MSS supports that LCME- and COCA-accredited institutions develop minimum content requirements in LGBTQ+ health curricula, including relevant terminology, health disparities, taking a comprehensive sexual history, developing inclusive clinical environments, gender-affirming care for transgender and nonbinary patients, gender-affirming physical exam skills, sexual health safety and satisfaction, and intersectional experiences of LGBTQ+ people. (MSS Res. 22, I-21)

295.235MSS  Single Licensing Exam Series for Osteopathic and Allopathic Medical Students: AMA-MSS will ask the AMA to encourage the development of a single licensing examination series for all medical students attending a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for osteopathic medical students. (MSS Res. 23, I-21) (AMA Res. 325, Adopted as Amended [ ], A-22)

295.236MSS  Supporting a Hybrid Residency and Fellowship Interview Process: AMA-MSS will ask the AMA to encourage appropriate stakeholders, such as the Association of American Colleges and Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews. (MSS Res. 38, I-21)

295.237MSS  Institutional Support for Medical Trainees who Experience Harassment: AMA-MSS will ask the AMA to work with relevant stakeholders to release a statement and advocate that the US Department of Education replate their 2020 Title IX rule on sexual harassment and assault in educational settings, including undergraduate and graduate medical education, with a comprehensive rule that preserves the safety and well-being of all people affected by sexual assault. (MSS Late Resolution 01, I-21)
Inclusion of Disability in Medical Student Mistreatment Reporting: AMA-MSS will ask that our AMA work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire. (MSS Res. 010, A-22)

Increased Education and Access to Fertility-Related Resources for U.S. Physicians: AMA-MSS will (1) work with appropriate stakeholders to develop gender and sexuality inclusive educational initiatives for medical trainees of all levels to raise awareness about the high rate of physician infertility, family planning options including cryopreservation, and the financial implications of fertility management and (2) urge academic and private hospitals and employers to offer family planning resources and counseling for options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians. (MSS Res. 014, A-22)

Incorporating Holocaust Education in Medical Schools on International Remembrance Day: AMA-MSS will ask that our AMA host an annual event in support of International Holocaust Remembrance Day (January 27) to provide education to medical trainees about the role of physicians in the Holocaust. (MSS Res. 055, A-22)

Expanding Support for Medical Students and Physicians with Disabilities

Our AMA-MSS will prioritize the input, direction, and partnership of members with personal and lived experience of disability, especially those with intersecting marginalized identities, to ensure those most impacted guide the direction of change. (MSS CDA CME Report A, A-22)

Medical Education: Financing and Support

A Voucher-Based Mechanism for Residency Position Funding: (1) AMA-MSS supports the establishment of a voucher system to provide entry eligibility for residents into graduate medical education programs and concurrently provide funding eligibility for the training program at the site where training occurs. (2) AMA-MSS supports the voucher system for funding of graduate medical education training positions for all graduates of US LCME and AOA-accredited medical schools with additional vouchers provided on a competitive basis to International Medical Graduates in a number determined by a public/private sector workforce planning group. (MSS Rep C, I-96) (CME Amended Rep 1, I-96 Adopted) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Tax Exemption for National Health Service Corps Scholarship: AMA-MSS supports federal legislation that will assure that tax-exempt status is returned to the direct medical school expense portion of the National Health Service Corps Scholarship program. (MSS Late Res 4, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

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305.058MSS  AMA-MSS Medical Student Loan & Financial Aid Online Education Resource: AMA-MSS will request that each medical school provide to the MSS its own up to date online resource explaining prior to enrollment its loan disbursement procedures and any private loans the school may offer. (MSS Sub Res 1, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

305.060MSS  Solutions to Tackling the Increasing Cost of Medical Education: AMA-MSS will ask the AMA to (a) support policies that ensure that funding gained by medical schools from all future increases to medical school tuition and fees be allocated directly to improve the education of medical students; and (b) support policies that ensure that all information related to the allocation of funds from tuition and fees increases be disclosed to all prospective and current medical students for each respective medical school campus; (2) AMA-MSS will work to develop print and electronic resources for our local chapters to utilize on their campuses to encourage their medical school deans to adopt policies that ensure transparency in medical school tuition and fees increases; (3) The AMA-MSS Governing Council will (a) continue to work with our AMA Council on Medical Education, the Association of American Medical Colleges (AAMC), and the AAMC Organization of Student Representatives (OSR) to encourage medical schools to adopt policies that ensure that all increases to medical school tuition and fees go towards direct improvements to medical student education.
305.061MSS **Student Loan Empowerment:** AMA-MSS will ask the AMA to support legislation that requires medical schools to inform students of all government loan opportunities along with private loans and requires disclosure of reasons that preferred lenders were chosen. (MSS Amended Res 16, I-07) (AMA Res 307, A-08, Adopted as Amended [H-295.869]) (Reaffirmed: MSS GC Report C, I-12) (Re reaffirmed: MSS GC Report A, I-17)

305.062MSS **Industry Support of Professional Education in Medicine:** AMA-MSS encourages aggressively decreasing reliance on industry support for medical education and supports alternative funding mechanisms to finance quality medical education. (MSS Res Late 4, A-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

305.067MSS **Eligibility Criteria for AMA Foundation Scholarships:** AMA-MSS will formally ask the AMA Foundation to consider allowing non-U.S. citizens attending U.S. medical schools to apply for AMA Foundation scholarships. (MSS Res 2, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

305.072MSS **Financial Aid Dependency Status of Medical Students:** AMA-MSS will encourage medical schools to institute an appeals procedure that allows individual students with extenuating familial circumstances to apply for institutional financial aid without parental tax information taken into consideration, such as students whose non-custodial parent’s whereabouts are unknown or students who have an established history of non-support from their parents. (GC Rep A, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

305.077MSS **Increasing Public Service Opportunities for Specialists:** AMA-MSS will ask the AMA to (1) encourage the National Health Service Corps and other relevant stakeholders to expand their scope and encourage the participation of specialists in order to ensure the provision of services in underserved communities; (2) work with state and federal governments, medical schools, the AAMC, and other relevant entities to encourage new loan forgiveness programs for specialists treating underserved patient populations; and (3) that our AMA urge states who opt-out of the ACA expansion of Medicaid to still comply with the increased reimbursement schedule for specialists treating Medicaid patients. (MSS Res 12, I-12) (AMA Policies D-200.978, D-200.980, D-200.982, D-200.985, H-200.954, D-305.960, D-305.973, D-305.975, D-305.979, D-305.993 and H-305.928 Reaffirmed in Lieu of Res 202, A-13) (Reaffirmed: MSS GC Report A, I-17)

305.081MSS **Addressing Student Debt in Medical School Attrition Due to Mental Illness:** AMA-MSS supports the study of mechanisms for dismissing federal loan obligations for students who withdraw from medical school due to a diagnosed mental and/or physical illness. (MSS Res 13, A-18)

305.082MSS **Understanding Philanthropic Efforts to Address Medical School Tuition:** AMA-MSS will (1) study the financial sustainability and factors enabling the implementation of tuition-free and tuition-reduced undergraduate medical education programs; and (2) study the efficacy of using tuition-free and
tuition-reduced undergraduate medical education programs to incentivize primary care specialty choice among medical students. (MSS Res 29, I-18)

305.083MSS MSS Financial Burden of Application to Medical School and Residency: The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:

1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants’ behavioral competencies into future AMA medical education funding initiatives.

2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.

3. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending an online forum where students can accommodate other medical students who are interviewing in their area.

(MSS GC Rep A, I-17)

305.084MSS Medical School Tuition: The AMA-MSS supports the following principles regarding medical school tuition:

1. That the AMA-MSS joins the AMA in its opposition of mid-year and retroactive medical school tuition and retroactive medical school tuition or fee increases and encourages collaborations in this oppositions, including the AAMC.

2. That the AMA-MSS will ask the AMA to study, in collaboration with state, specialty, and other interested organizations, the case precedent, timing, risks, and other considerations in filing an application for injunctive relief to block retroactive or mid-year tuition increase.

3. That the AMA-MSS will encourage state and county medical societies to develop policy and lobby state legislatures to help restrain medical school tuition increases including, but not limited to, state subsidies to public and private medical schools within their state.

4. That the AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition
increases that may be necessary should be imposed on the entering class.
5. That the AMA-MSS joins the AMA in its opposition of medical school tuition taxes and any other attendance-based taxes imposed on medical students by any government entity.
6. That the AMA-MSS will ask the AMA to discourage U.S. medical schools from requiring accepted international students to pay more than a single term’s tuition at each billing period, in the same manner as the rest of the U.S. citizens and permanent U.S. residents within the student body.

(MSS GC Rep A, I-17)

**Medical Students Federal Loans:** The AMA-MSS supports the following principles regarding federal loans and taxation:

1. The AMA-MSS supports actively lobbying for legislation aimed at establishing an affordable student loan structure with a variable interest capped at no more than 5.0%.
2. The AMA-MSS supports and will ask the AMA to support government-sponsored in-school loan interest subsidies should be maintained.
3. The AMA-MSS will ask the AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate.
4. The AMA-MSS will ask the AMA to lobby for passage of legislation that would (1) eliminate the cap on the student loan interest deduction, (2) increase the income limits for taking the interest deduction, (3) an increase to annual and aggregate loan limits to better reflect the true cost of medical education at the student applicant’s medical school, (4) include room and board expenses in the definition of tax-exempt scholarship income.
5. The AMA-MSS will ask the AMA to support legislation that does not require medical students attending school full-time twelve months per year to provide summer earnings allowances as partial fulfillment of their loan requirements.
6. The AMA-MSS will ask the AMA to lobby for passage of legislation that would make permanent the education tax incentives that our AMA successfully lobbied for as part of the Economic Growth and Tax Relief Reconciliation Act of 2001.
7. The AMA-MSS will ask the AMA to oppose legislation that would allow medical school scholarships or fellowships to be subject to federal income or social security taxes (FICA).
8. The AMA-MSS will encourage members to write letters to senators and representatives, especially those on the appropriate specific subcommittees, to support the visitation of the issue of how interest rates on student loans are determined and will provide a sample letter of support for this cause to AMA-MSS members so that members can simply sign and forward the letter to their respective governmental representatives.

(MSS GC Rep A, I-17)
Medical Student Dependent and Spousal Care: The AMA-MSS supports the following principles regarding the care of medical school students’ spouses and dependents:

1. That the AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, healthcare, and dependent care for all dependents.
2. That the AMA-MSS supports and will ask the AMA to work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent, spousal and same-sex spousal equivalent health insurance, dependent care, and dependent living expenses be included both as part of the “cost of attendance” and as an educational expense in medical student financial aid budgets.
3. That the AMA-MSS ask its Council on Medical Education, Academic Physician Section and Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses.
4. The AMA-MSS supports and will ask the AMA to support the Parent Loan Program and its expansion so that parents and spouses of medical students can borrow at less than market rates.

(MSS GC Rep A, I-17)

Voluntary Service-Payback and Loan Repayment Programs: The AMA-MSS supports the following principles regarding voluntary service-payback and loan repayment programs:

1. The AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs and support the development of other voluntary programs that finance medical students through their undergraduate training in exchange for their service in underserved areas.
2. The AMA-MSS will ask the AMA to advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program.

(MSS GC Rep A, I-17)

Increasing Availability and Access to Financial Aid: The AMA-MSS supports the following principles regarding access to student loans and availability of financial aid and scholarship monies:

1. That the AMA-MSS will ask the AMA to ask state medical societies to develop and implement interest-subsidized guaranteed student loan programs via the private sector in order to maintain a choice of funding to students.
2. That the AMA-MSS will ask the AMA to recommend that state medical societies raise funds for such programs by physician contributions over a short, but definite, term.
3. That the AMA-MSS will ask the AMA to work with state medical societies, associated foundations and medical schools to ensure that information about all offered scholarships is readily available online.
4. That the AMA-MSS will ask the AMA to encourage societies to support further expansion of state loan repayment programs, and expansion of those programs to cover physicians in non-primary care specialties.

5. That the AMA-MSS will ask the AMA to urge each state medical society strongly to add a voting medical student representative to its foundation Board of Directors or other appropriate governing body in addition to collecting and propagating bylaw changes from state societies that have added a medical student vote to their Board of Directors.

6. That the AMA-MSS will ask the AMA to urge, via its component state medical societies, all state foundations to consider converting any loan programs they may have into scholarship programs and provide information to said foundations on how other states have achieved this conversion.

7. That the AMA-MSS will ask the AMA to request that the state foundations and the AMA Foundation encourage donors to pool their funds with others to endow large scholarships.

8. That the AMA-MSS will ask the AMA to request that the AMA Foundation work with state medical societies and their foundations to (1) make scholarship programs direct-application at the medical school level, (2) ensure that scholarship funds are disbursed directly to the student, not to the medical school.

9. That the AMA-MSS will ask the AMA to request that the AMA Foundation compile and distribute to the state foundations a list of fundraising “best practices” that have been shown to be effective in raising funds for medical scholarships.

(MSS GC Rep A, I-17)

305.089MSS Medical Student Debt Management Education: The AMA-MSS supports the following principles regarding financial management and debt education of medical students:

1. That the AMA-MSS will ask the AMA to encourage medical school financial aid offices to educate medical students in medical debt management and provide financial and tax counseling.

2. That the AMA-MSS will ask the AMA to assist medical school financial aid offices in implementing debt management, financial, and tax counseling and education services.

3. That the AMA-MSS will encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.

4. That the AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants.

5. That the AMA-MSS ask the Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical colleges to provide additional data to students and applicants including by not limited to: (1) average debt incurred in medical school for graduation students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles,
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(1) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution.

(MSS GC Rep A, I-17)

305.090MSS  Medical Student Loan Forgiveness: The AMA-MSS supports the following principles regarding student loan forgiveness:

1. That the AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as a means of effectively addressing the urgent financial needs of medical students.

2. That the AMA-MSS will ask the AMA to oppose the reduction and support that expansion of medical student and physician benefits and eliminate requirements for qualification under Public Service Loan Forgiveness.

3. That the AMA-MSS will ask the AMA to study the feasibility and utility of loan forgiveness programs for the private sector including, but not limited to, the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency.

(MSS GC Rep A, I-17)

305.091MSS  Understanding Philanthropic Efforts to Address the Rise of Medical School Tuition: AMA-MSS will 1) continue to study this topic to gain a better understanding of the sustainability of free and reduced medical tuition programs and of the efficacy of these programs in effecting medical specialty choice; and 2) regularly track the tuition reimbursement programs across medical schools to monitor outcomes. (MSS COLRP/CME Rep A, A-19)

305.092MSS  Modifying Eligibility Criteria for the Association of American Medical Colleges’ Financial Assistance Program: AMA-MSS will ask the AMA to encourage the Association of American Medical Colleges’ (AAMC) to conduct a study of the financial impact of the current Fee Assistance Program (FAP) policy to medical school applicants. (MSS Res. 24, I-19) (AMA Res. 315, Adopted as Amended with Title Change [], A-22)

305.093MSS  Reducing Complexity in the Public Service Loan Forgiveness: Our AMA-MSS will ask the AMA to amend H-305.925, by addition and deletion as follows:

PRINCIPLES OF AND ACTIONS TO ADDRESS MEDICAL EDUCATION COSTS AND STUDENT DEBT, H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans
Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
(i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. 18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will:
(a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as
Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (h) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

(MSS Res. 055, Nov. 2020)

310.000MSS  Medical Education: Graduate

310.001MSS  The Residency Match Process: The AMA-MSS recognizes the significant time, energy, and resources that are allocated to the residency match process and hereby supports the following principles to help improve the residency match process: 1. That the AMA-MSS will continue to work with other student, resident, and physician organizations to research and promote changes in the structure and/or the rules governing the Match so as to maximize the advantage to medical students and residents. 2. That the AMA-MSS supports efforts to encourage residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants’ schedules. 3. That the AMA-MSS supports efforts to encourage the ACGME, the AOA, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately. 4. That the AMA-MSS supports a
change in the NBME policy to report examination scores as “pass-fail” only. 5. That the AMA-MSS encourages individual chapters to maintain a roster of students willing to host residency applicants when they visit their institution. 6. That the AMA-MSS will ask the AMA to work with the NRMP to keep transaction costs of the Match to reasonable levels, and ensure that fees charged for each program a medical student applies to be capped at a reasonable level that takes into account medical students’ budgeting constraints. 7. That the AMA-MSS will ask the AMA to support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels. 8. That the AMA-MSS will ask the AMA to urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances, including but not limited to: unforeseen family emergencies such as illness that would require the individual to care for a family member; unforeseen physical or mental health problems that would impede the individual’s ability to participate in residency training and required military or foreign service duty. 9. That the AMA-MSS will ask the AMA to support the concept that programs should retain the ability to extend applicants positions outside the Match. 10. That the AMA-MSS will ask the AMA to support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional “Match Day” date in mid-March. (MSS GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)


310.003MSS MSS Graduate Medical Education Financing: 1. The AMA-MSS joins the AMA in its strong opposition to the reduction of Medicare Funding of graduate medical education and will advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions. 2. The AMA-MSS joins the AMA in its position that all payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding through, for example, expansion of government grant opportunities. 3. The AMA-MSS will ask the AMA to work together with other stakeholders to actively lobby Congress for legislation requiring all payers to contribute towards graduate medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid graduate medical education payments. 4. The AMA-MSS urges the AMA to work toward the removal of caps on residency programs funded by the Center for Medicare and Medicaid Services (CMS), and encourage the CMS to adjust Graduate Medical Education funding to account for the need of an expanded workforce. 5. The AMA-MSS supports the AMA (a) with consultation of interested stakeholders, developing a comprehensive framework for a
sustainable graduate medical education financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; (b) advocating for pilot projects supported through state and/or federal funding in medically underserved areas that foster resident training programs and offer loan repayment as a means to address the physician workforce shortage; and (c) working with our state medical societies for the drafting and implementation of model legislation to enact a comprehensive plan for graduate medical education reform once such a plan is developed. 6. The AMA-MSS supports combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream. 7. The AMA-MSS support that Medicare’s Graduate Medical Education funding be a per-resident federal allocation that is adjusted according to solely geographic measures, such as cost-of-living. 8. The AMA-MSS will advocate for transparency in how graduate medical education funds are allocated to residency programs and for how those programs use the allotted funding. 9. The AMA-MSS support that the payment of Graduate Medical Education funding being directed to the designated residency GME Office, in lieu of the hospital system, to be allocated across the department(s), sites and other specialties to provide comprehensive training. 10. The AMA-MSS will publicize in an appropriate manner, to all medical students, the potential for the elimination or reduction of Medicare Funding of graduate medical education and the consequential development of uncompensated residency positions. 11. The AMA-MSS opposes further expansion of graduate medical education funding to non-physician “residencies” at the expense of Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 12. The AMA-MSS supports legislation regarding new funding for primary care graduate medical education designated for Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 13. The AMA-MSS supports direct graduate medical education funding that allows each resident an initial residency period of five years, regardless of specialty choice or minimum years to attain board certification, in order to ensure flexibility of career choice. (GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)


Resident Work Hours: AMA-MSS will ask the AMA to: (1) draft original, modify existing, or oppose legislation and pursue regulatory or administrative strategies when dealing with resident work hours and conditions; (2) continue to work with organizations like the Accreditation Council on Graduate Medical Education (ACGME) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms; and (3) encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patients safety and to explore possible solutions to the problem of work hours and conditions. (MSS GC Rep Late A, I-01) (AMA Amended Res 310, I-01 Adopted [D-310.990, H-310.928]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Resident/Fellow Work and Learning Environment: AMA-MSS supports the following general principles regarding resident/fellow duty hours to promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; (2) The total number of duty hours should not exceed 80 hours when averaged over a four-
week period; (3) Trainees must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; (4) Scheduled on-call assignments should not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; (5) Limits on duty hours must not adversely impact the organized educational activities of the residency program; (6) Scheduled time providing patient care services of limited or no educational value should be minimized; (7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; (8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important to patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; (9) The Joint Commission should create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (10) The Joint Commission should establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; (11) The AMA Council on Legislation should serve as the coordinating body in the creation of legislative and regulatory options.


310.031MSS Resident/Fellow Work and Learning Environment: (1) AMA-MSS will ask the AMA to work with the ACGME to refine the duty hours standards, and work with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation; (2) AMA-MSS will (a) continue to work, along with AMA-RFS, with groups such as the Committee of Interns (CIR) on collaborative efforts to see that duty hour reform is enforced and (b) continue to work to improve working conditions for residents and fellows. (MSS Rep D, A-03) (AMA Amended Res 322, A-03 Adopted; Resolve 8, Referred) (Amended: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-19)

310.033MSS Eliminating Religious Discrimination from Residency Programs: AMA-MSS will ask the AMA to: (1) encourage the adoption of residency requirements that allow individuals to honor their religious beliefs and practices; (2) encourage the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to extend its current policies regarding religious exceptions to include the observance of religious holidays and observances; (3) encourage the Accreditation Council for Graduate Medical Education to require that all residency programs become aware of and make an effort to ensure that residents be allowed to practice in a manner that does not interfere with their religious convictions, including observance of religious holidays and observances. (MSS Rep E, A-04) (AMA Res 308, A-05 Referred) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

310.034MSS Compensation for Resident/Fellow Physicians: The AMA-MSS recognizes the tremendous value of GME for patients and supports systems wherein adequate compensation is provided during GME training and supports the following
principles regarding resident/fellow compensation: 1. The AMA-MSS supports reforming the current system of determining residents’ salaries so that a resident’s level of training, cost of living, whether or not they work in an underserved area, and other factors relevant to appropriate compensation of residents are taken into account. 2. The AMA-MSS asks that our AMA (a) work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians reflect the unique and extensive amount of education and experience acquired by physicians; (b) study the use of collective bargaining with residency programs participating in the Accreditation Council for Graduate Medical Education to ensure fair and equitable terms of employment for resident physicians; (c) study the creation of a body that would establish and monitor criteria for fair and equitable terms of employment for resident physicians. (MSS GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)

310.039MSS Opposition to Protected Sleep Time: AMA-MSS will ask the AMA to (a) support additional study of the issues raised with respect to duty hours in the 2008 Institute of Medicine report, Resident Duty Hours: Enhancing Sleep, Supervision, and Safety, and consider further modifications of the current duty hours requirements based on the results of this inquiry; and (b) support the evaluation and improvement of duty hours reform that does not include protected sleep time. (MSS Amended Res 3, A-09) (AMA Res 303, A-09 Referred) (Modified and Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

310.041MSS Improving Primary Care Residency Training to Advance Health Care for LGBTQ+ Patients: AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for caring for LGBTQ+ pediatric patients. (MSS Res 11, A-10) (AMA policy H-295.878 Amended in Lieu of AMA Res 906, I-10) (Reaffirmed, MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)

310.042MSS Medical Student Position Regarding the 2010 ACGME Residency Work Standards: AMA-MSS: (1) supports programs focused on improving patient care with clear and measurable outcomes while paying equal attention to other initiatives that have been shown to minimize preventable medical errors and that the decision of whether to impose additional limitations on medical student, resident and fellow duty hours should be based on the prevailing evidence; (2) supports additional efforts to improve patient safety outside of limiting medical student, resident, and fellow work hours, including more adequate training in the art of transitioning care and identification of limitations due to sleep deprivation; and (3) supports supervision of medical students, residents and fellows that allows for competency based independence and delegation of clinical responsibility appropriate for level of training. (MSS Res 15, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies: AMA-MSS supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning, and counseling for unintended pregnancy. (Late Res 2, A-13) (Reaffirmed: MSS GC Rep A, I-19)

Equal Paternal and Maternal Leave for Medical Residents: That our AMA amend policy H-405.960 by insertion and deletion as follows:

H-405.960 Policies for Maternity, Family and Medical Necessity Leave

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement; (2) Recommended components of maternity and paternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption; and (j) leave policy for paternity. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking maternity and paternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity and paternity leave policies a six-week minimum leave allowance, with the understanding that no woman or man should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption;
(b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice equal to maternity leave benefits; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating maternity and paternity leave and alternative schedules for pregnant house staff; and (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year; and (14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

(AMA Res 904, I-14 Adopted as Amended) (Reaffirmed: MSS Res 58, A-18)
workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create a supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

310.055MSS Improving Support and Assistance for Medical Students with Disabilities: AMA-MSS (1) supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and (2) supports the development of training and guidance for medical school faculty and administrators on: (a) communicating with and about persons with disabilities, (b) writing appropriate technical standards for applicants, medical students, and residents, and (c) identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM). (MSS Res 33, A-18)

310.056MSS Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation: Our AMA-MSS will ask the AMA to collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited Residency Programs. (MSS COLRP CME Rep. A, Nov. 2020)

310.057MSS Supporting Accountable Organizations to Residents and Fellows: AMA-MSS supports efforts to determine which organizations or governmental entities are best suited for being permanently responsible for and accountable to residents and fellows without conflict of interest. (MSS Res. 073, A-21)

310.058MSS Reporting of Residency Demographic Data: AMA-MSS will ask the AMA to: (1) work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years; and (2) encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty. (MSS WIM CHIT Rep. A, I-21)
315.000MSS  Medical Records

315.001MSS  Patient Confidentiality and Government Investigations: AMA-MSS opposes the implementation of federal legislation that would enable any government agency or representative of such agency to access a patient’s medical records without the patient’s knowledge and consent or court order. (MSS Amended Sub Res 11, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

315.002MSS  Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals: AMA-MSS supports added safeguards, such as audits or “break the glass” access, for medical student records when those records are placed in the same system used for patients at the school’s affiliated hospitals. (MSS Res 13, I-12) (Reaffirmed: MSS GC Report A, I-17)

315.003MSS  Enabling a Contiguous, National Electronic Health Record Network: AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13) (Reaffirmed: MSS GC Rep A, I-19)


315.005MSS  Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation: AMA-MSS will ask (1) that our AMA support the inclusion of a patient’s biological sex, gender identity, sexual orientation, pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive manner; and (2) that our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health. (MSS Res 09, A-16) (Amended: LGBTQ+ Affairs Report A, A-21)

315.006MSS  Improving Cybersecurity in Healthcare Facilities: AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge. (MSS Res 07, I-16) (Reaffirmed: MSS Res. 101, Nov. 2020)

315.007MSS  Integration of Drug Price Information Into Electronic Medical Records: Our AMA-MSS will ask the AMA to (1) support the incorporation of estimated
patient out of pocket drug costs into electronic medical records in order to help reduce patient cost burden; and (2) collaborate with invested stakeholders, such as physician groups, Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out of pocket drug costs into electronic medical records in order to help reduce patient cost burden. (MSS Res 01, I-16) (AMA Res 219, A-17 Referred)

315.008MSS Considerations for Immunity Credentials during Pandemics and Epidemics: Our AMA-MSS will ask the AMA to:
(1) oppose the implementation of natural immunity credentials which give an individual differential privilege on the basis of natural immune status to a pathogen, and
(2) caution that any implementation of vaccine-induced immunity credentials, which give an individual differential privilege on the basis of acquired immunity after receiving a vaccine, must strongly consider potential consequences on social inequity, including but not limited to: (i) continued marginalization of communities historically harmed or ignored by the healthcare system; (ii) isolation of populations who may be ineligible for or unable to access vaccines; (iii) barriers preventing immigration or travel from countries with low access to vaccines and the need to offer a vaccine upon arrival to anyone entering the US from another country; and (iv) privacy of and accessibility to any systems used to implement vaccine-induced immunity passports. (MSS Res. 029, Nov. 2020) (Amended MSS CSI CHIT Report A, A-21) (BOT Rep. 18 Adopted in Lieu of HOD Res. 230, A-21, [X-XXX])

325.000MSS Medical Societies


345.000MSS Mental Health

345.001MSS De-institutionalization of Patients with Psychiatric Disorders: AMA-MSS will ask the AMA to: (1) support the concept that the deinstitutionalization of former patients with psychiatric disorders should be accompanied by adequate support from the community in the form of rehabilitation and counseling services; and (2) affirm the basic human rights of patients in board and care facilities to receive proper nutrition, essential medical care, adequate housing, community support, and to be permitted to participate in decisions regarding their environment. (AMA Res 160 A-79 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
345.002 MSS  An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses: AMA-MSS will ask the AMA to: (1) work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and (2) work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students. (MSS Sub Res 22, I-05 Adopted in Lieu of Res 12 and 13) (AMA Amended Res 412, A-06 Adopted [H-345.984]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

345.003 MSS  Improving Pediatric Mental Health Screening: AMA-MSS will ask the AMA to (1) recognize the importance of, and support the inclusion of, mental health screening in routine pediatric physicals; and (2) work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health concerns in primary care settings. (MSS Res 29, A-10) (AMA Res 414, A-11 Adopted as Amended [H-345.977]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

345.004 MSS  Stigmatization of Mental Health Disorders within the Medical Profession: AMA-MSS will ask the AMA to address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization. (MSS Res 37, A-11) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

345.006 MSS  Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence: AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows:

H-430.989 Disease Prevention and Health Promotion in Correctional Institutions

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward 1. the prevention and control of HIV/AIDS, substance use disorder, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as substance use disorder, and 3. a reduction in reincarceration rates related to substance use disorders and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, and drug treatment center staff, and psychiatric care center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing."
Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications: AMA-MSS aims to reduce stigmatization of mental health issues in the medical community by (a) opposing state medical boards’ practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician’s private health record confidentiality by requiring access to these records when an applicant reports treatment. (MSS Res 17, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Improving the Intersection Between Law Enforcement and Persons with Psychiatric Disorders: AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool for 1) educating law enforcement officers about persons with psychiatric disorders, 2) diverting offenders with psychiatric disorders from jails and prisons to medical treatment centers, and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health crises; and supports the National Mental Health Alliance and other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as CIT, that are designed to improve law enforcement’s responses to those with psychiatric disorders. (MSS Res 5, A-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools: AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel: AMA-MSS will ask (1) that our AMA support efforts to decriminalize suicide attempts in the military and (2) that our AMA support efforts to provide treatment for survivors of suicide attempt in lieu of punishment in the military. (MSS Res 26, A-16) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 001, I-16) (Reaffirmed: MSS GC Report A, I-21)
Improving Mental Health at Colleges and Universities for Undergraduates: AMA-MSS will ask (1) that our AMA support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; (2) that our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and (3) that our AMA support collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner. (MSS Res 30, A-16) (Reaffirmed: MSS GC Report A, I-21)

Addressing Medical Student Mental Health Through Data Collection and Screening: AMA-MSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (MSS Res 14, I-16) (AMA Res 303, A-17 Adopted as Amended [appended to H-295.858]) (Reaffirmed: MSS GC Report A, I-21)

Studying the Effectiveness of Telemental Health in Schools: AMA-MSS supports research by appropriate stakeholders assessing the effectiveness of telemental health programs in comparison to standard mental health services offered by elementary, middle, and secondary educational institutions. (MSS Res 20, I-16) (Reaffirmed: MSS GC Report A, I-21)

Co-Location of Behavioral Health Care and Primary Care: AMA-MSS supports the co-location of behavioral health services within primary care clinics and other locations where primary care services are provided. (MSS Res 11, A-17)

Addressing Social Media Usage and its Negative Impacts on Mental Health: AMA-MSS will ask that our AMA (1) collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians’ knowledge of the health impacts of social media usage, and (b) to develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and (2) advocate 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 usage. (MSS Res 41, A-17)

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness: AMA-MSS will ask the AMA to (1) oppose restrictive housing for incarcerated persons with mental illness and (2) encourage appropriate stakeholders to continue to develop and implement alternatives to restrictive housing for incarcerated persons with mental illness in all correctional facilities. (MSS Res 04, I-17)

Support Mental Health Screenings for Detained Minority Youth: (1) AMA-MSS supports equal and appropriate mental health referrals in the detained minority youth
population; (2) AMA-MSS advocates for nondiscriminatory mental health screenings for all juvenile delinquents prior to admission; and (3) AMA-MSS supports focused funding on research and regular evaluations to decrease disparities in mental health screening protocols at juvenile detention centers. (MSS Res 39, A-18)

345.018MSS Support for the Use of Psychiatric Advance Directives: AMA-MSS will ask the AMA to support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (MSS Res 04, A-19) (AMA Res. 001, Refer for Study, I-19)

345.019MSS Support for Veterans Courts: AMA-MSS will ask the AMA to support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder. (MSS Res 24, A-19) (AMA Res. 202, Adopt as Amended [H-510.979], I-19)

345.020MSS Limiting the Use of Restrictive Housing in Adult Correctional Facilities: AMA-MSS will: (1) oppose the use of restrictive housing in adult correctional facilities for disciplinary purposes or pending investigation of a suspected rule violation for more than 15 consecutive days; (2) support efforts to ensure that the mental and physical health of all individuals in restrictive housing are regularly monitored by health professionals; and (3) support the development and use of safe alternatives to restrictive housing in adult correctional facilities. (MSS Res 26, A-18)

345.021MSS Support for Mental Health Courts: AMA-MSS supports the establishment and use of mental health courts, including drug courts and sober courts, as an effective method of intervention for individuals with mental illness and substance use disorders who are convicted of nonviolent crimes and the state and local level in the United States. (MSS Res. 29, I-19) (Reaffirmed: MSS Res. 030, Nov. 2020)

345.022MSS Support for Mental Health Courts: Our AMA-MSS will ask the AMA to amend policy H-100.955, Support for Drug Courts, by addition and deletion as follows:

SUPPORT FOR MENTAL HEALTH DRUG COURTS, H-100.955
Our AMA: (1) supports the establishment and use of mental health drug courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports; (2) encourages legislators to establish mental health drug courts at the state and local level in the United States; and (3) encourages mental health drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (MSS Res. 019, Nov. 2020)

345.023MSS Mental Health First Aid Training: Our AMA-MSS will ask the AMA to encourage appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical boards, and state
medical boards to provide access to evidence-based mental illness rescue training programs as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.

(MSS Res. 030, Nov. 2020)

345.024MSS  Employment of Patients with Psychiatric Illness: Our AMA-MSS: (1) recognizes the role that employment has in improving the health and quality of life for patients with psychiatric disorders and (2) supports the employment of patients with psychiatric illness through measures such as the develop of Individual Placement and Support (IPS) programs.

(MSS Res. 051, Nov. 2020)

345.025MSS  Standardized Wellness Initiative Reporting: AMA-MSS will ask the AMA to amend Policy D-345.983 by addition and deletion as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicided to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents and medical students. ; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place, to inform and promote meaningful mental health and wellness interventions in these populations.


350.000MSS  Minorities

350.001MSS  Minority and Disadvantaged Medical Student Recruitment and Retention Programs: AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose economically disadvantaged students to the career of medicine; special summer programs to bring minority and economically disadvantaged students to medical schools for an intensive exposure to medicine; and conduct retention programs for minority and economically disadvantaged medical students who may need assistance. (AMA Res 35, I-79 Referred) (CME Rep T, I-79, Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E,
350.003MSS Minority Representation in the Medical Profession: AMA-MSS will ask the AMA to:

350.004MSS Funding for Affirmative Action Programs: AMA-MSS will ask the AMA to:


350.012MSS Opposing Legislation to Cut Funding to the HRSA Health Careers Opportunity Program and the HRSA Centers of Excellence Program: AMA-MSS will ask the AMA to: (1) publicly oppose any reduction or elimination of funding for the Health Careers Opportunity Program and the Centers of Excellence Program; and (2) work with other interested organizations to seek increased public and private sector funding for the Health Careers Opportunity Program and the Centers of Excellence Program. (MSS Res Late 2, I-06) (Amended CME Rep 1 Adopted in Lieu of AMA Res 830, I-06 [D-200.985]) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)
350.013MSS Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations: AMA-MSS will ask the AMA to encourage the National Institutes for Mental Health (NIMH) and local health departments to examine national and regional variations in psychiatric illnesses among immigrant and minority populations with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations. (Sub MSS Res 25, A-12) (Reaffirmed: MSS GC Report A, I-17)

350.014MSS Youth Health Pipeline Programs Initiative: AMA-MSS (1) supports the establishment of a Medical Education Outreach Subcommittee for Disadvantaged Students, i.e., defined socially, economically, and/or educationally, under the umbrella of the Minority Issues Committee and under mentorship of the Minority Affairs Section, with the mission of forming long-term partnerships with local medical societies to develop pipeline programs that increase underrepresented in medicine (UIM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical school AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, the Association of Native American Medical Students, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (UIM) and disadvantaged students. (MSS Res 27, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

350.015MSS Patient and Physician Rights Regarding Immigration Status: AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (MSS Res 15, A-17, Immediate Transmittal) (AMA Res 018, A-17 Adopted [H-315.966])

350.016MSS Improving Medical Care in Immigration Detention Centers: AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigration and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigration and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A-17 Adopted as Amended [D-350.983])

350.017MSS Disaggregation of Data Concerning the Status of Asian-Americans: AMA-MSS will ask that our AMA support the disaggregation of data regarding Asian-Americans in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. (MSS Res 27, A-17)
Defense of Affirmative Action: AMA-MSS will ask the AMA to oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. (MSS Res 38-I-17, HOD Res 207 I-18 Adopted)

Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level: AMA-MSS will (1) support the collaboration between local chapters and allied medical student organizations, including but not limited to Student National Medical Association, Latino Medical Student Association, and Asian Pacific American Medical Student Association, in order to increase underrepresented minority medical student participation in the AMA-MSS, and (2) support regional leadership in promoting Local Chapter creation of a Minority Liaison executive committee position aimed at increasing collaboration between the AMA-MSS and minority student organizations. (MSS Res 19, A-19)

Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities: AMA-MSS will ask the AMA to 1) amend H-315.996 by insertion to read as follows:

Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records H-315.996

The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient.; and

2) encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity.

Addressing the Racial Pay Gap in Medicine: AMA-MSS will ask the AMA to (1) support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment; and (2) support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries of race and medical physicians. (MSS Res 42, A-19) (AMA Res. 007, Adopt as Amended [H-385.906], I-19)

Presence and Enforcement Actions of U.S. Immigration and Customs Enforcement (ICE) at Healthcare Facilities: AMA-MSS will ask the AMA to (1) advocate for and support legislative efforts to designate such healthcare facilities as sensitive locations; (2) work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourage healthcare facilities to
clearly demonstrate and promote their status as sensitive locations; and (4) oppose the presence of U.S. Immigration and Customs Enforcement (ICE) at healthcare facilities. (MSS Res 43, I-17) (AMA Res 232, I-17, Adopted [D- 160.921])

350.023MSS  
Amending H-350.957, Addressing Immigrant Health Disparities to Include Opposition to Legislation that Forces Decisions between Health Care and Lawful Residency Status: AMA-MSS will ask the AMA to amend H-350.957, Addressing Immigrant Health Disparities by insertion as follows:

H-350.957 – Addressing Immigrant and Refugee Health Disparities
1. Our American Medical Association recognized the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medical accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees, and asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status.

(MSS Res 07, I-19) (Reaffirmed, MSS Res. 21, I-21)

350.024MSS  
Using X-Ray and Dental Records for Assessing Immigrant Age: AMA-MSS will ask the AMA to support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant’s age. (MSS Res. 21, I-19)

350.025MSS  
Racism as a Public Health Threat: AMA-MSS will ask the AMA to: (1) acknowledge that historic and racist medical practices have caused and continue to cause harm to marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care; (3) identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognized, address and mitigate the effects of racism on patients, providers, and populations; (4) encourage the development, implementation, and evaluation of undergraduate, graduate and continuing medical education programs and curricula that engender greater understanding of (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and (b) how to prevent and ameliorate the health effects of racism; (5) (a) supports the
development of policy to combat racism and its effects and (b) encourages governmental agencies and nongovernmental organizations to increase funding of research into the epidemiology of risks and damages related to racism and how to prevent or repair them; and (6) work to prevent and combat the influences of racism and bias in innovative health technologies; and (7) encourage the AMA Foundation to create new scholarships, research grants, and awards to support outstanding academic and community efforts related to the impact of systemic racism on health. (MSS Res. 30, I-19) (Adopted, AMA Res. 005, Nov. 2020) (Reaffirmed: MSS Res. 010, Nov. 2020) (Appended: MSS Res. 016/032, Nov. 2020)

350.026MSS Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: AMA-MSS will ask the AMA to (1) recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) oppose discrimination against individuals based on their hair or cultural headwear in healthcare settings; (3) acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; and (4) encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (MSS Res. 34, I-19) (AMA Res. 006, Adopt as Amended [H-65.949], A-22)

350.027MSS Status of Immigration Laws, Rules, and Legislation during National Crises: In order to recognize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic, our AMA- MSS will ask our AMA to: (1) oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; (2) oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; (3) support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and (4) oppose utilizing public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution. (MSS Res. 013, Nov. 2020)
Denouncing Racial Essentialism in Medicine: Our AMA-MSS: (1) recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; (2) encourages characterizing race as a social construct, rather than an inherent biological trait, and recognize that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism that an proxy for genetics; (3) collaborates with the AAMC, AACOM, NBME, NBOME, other national-level stakeholders across the various domains of health care education and public health and content experts to identify and address aspects of medical and health care education and examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; (4) collaborates with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and (5) supports research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
(MSS Res. 016/032, Nov. 2020)

Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent: AMA-MSS will ask the AMA to: (1) add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographic forms; (2) work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories; and (3) work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all medical schools and residency demographic forms.
(MSS Res. 035, A-21) (AMA Res. 019 Adopted in Lieu of AMA Res. 002, I-21 [D-350.979])

Exclusion of Race and Ethnicity in the First Sentence of Case Reports: AMA-MSS will ask the AMA to: (1) encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation and (2) encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation.

Indigenous Data Sovereignty: AMA-MSS will ask (1) that our AMA recognizes that American Indian and Alaska Native Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties, (2) that our AMA supports that American Indian and Alaska Native (AI/AN) Tribes and Villages’ Institutional Review Boards and research departments retain the right to oversee and regulate the collection, ownership, and management of research data generated by their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46, (3) that our AMA AMA encourages the use and regular review of data-sharing agreements for all studies between academic medical centers and American Indian and Alaska Native Tribes and Villages, and (4) that our AMA encourages the National Institutes of Health and other stakeholders to provide flexible funding to American Indian and Alaska Native Tribes and Villages for research efforts, including the creation and maintenance of Institutional Review Boards (IRBs).
(MSS Res. 031, A-22)
Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants: AMA-MSS will ask that our AMA work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, the Association of American Medical Colleges, and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process. (MSS Res. 037, A-22)

Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care: Our AMA: (1) recognizes the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation; (2) supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause; (3) will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause; and (4) supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems. (MSS CAIA Report A, A-22) (HOD Res. 442, A-22)

**Nurses and Nursing**

Increasing the School Nurse to Student Ratio: AMA-MSS will ask the AMA to (1) encourage state medical societies and organizations, such as the National Association of School Nurses and other stakeholders, to advocate at all levels for adequate funding of school nurse positions; and (2) encourage public schools, private schools, and other relevant organizations to employ school nurses in a manner that complies with CDC recommended nurse-to-student ratios. (MSS Res 23, A-12) (Reaffirmed: MSS GC Report A, I-17)

Increasing Patient Access to Sexual Assault Nurse Examiners: AMA-MSS will ask the AMA to advocate for increased patient access to Sexual Assault Nurse Examiners in the Emergency Department, including the transfer of victims to other facilities with Sexual Assault Nurse Examiners when they are not available. (MSS Res 12, A-18)

**Occupational Health**

Regulation of Occupational Carcinogens: AMA-MSS will ask the AMA to: (1) endorse the principle of using the best available scientific data including animal models as a basis for regulation of occupational carcinogens; and (2) urge OSHA to reinstate its regulation of carcinogens on the basis of best

365.002MSS Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers: AMA-MSS will ask the AMA to: (1) encourage OSHA to adopt industry-wide standards which guarantee a health care worker’s right to confidentiality, appropriate counseling, and treatment following the positive conversion of a tuberculosis test; and (2) encourage OSHA to adopt industry- wide standards that guarantee that all prospective health care workers have a right to confidentiality, appropriate counseling, and treatment referral following a positive tuberculosis test, which was obtained as a result of a pre- employment physical examination. (MSS Sub Res 5, I-96) (AMA Sub Res 210, A-97 Adopted [H-440.905]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

365.004MSS Hospital Workplace and Patient Safety and Weapons: (1) AMA-MSS supports policies which restrict guns and Tasers in civilian health care delivery settings and (2) AMA-MSS supports comprehensive training of security personnel that focus on patient safety and empathy. (MSS Late Res 01, A-16) (Reaffirmed: MSS GC Report A, I-21)

365.005MSS Reimbursement for Post-Exposure Protocol for Needlestick Injuries: AMA-MSS will ask the AMA to (1) encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state’s workers’ compensation, where applicable; and (2) encourage state societies to work with their respective workers’ compensation program to include medical students as recipients of medical benefits in the event of blood or body substance exposure sustained during clinical rotations. (MSS Res 11, A-19) (AMA Res. 801, Adopt as Amended [H-295.855], I-19)

365.006MSS Call for Improved Personal Protective Equipment (PPE) Design and Fitting: Our AMA-MSS will ask the AMA to encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers. (MSS Res. 085, Nov. 2020)

365.007MSS Advocating for Heat Exposure Protections for Outdoor Workers: AMA-MSS will: (1) support advocating for outdoor workers to have access to preventive cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language; (2) support legislation creating a federal standard for protections against heat stress specific to the hazards of the workplace; and (3) support working with the United States Department of Labor, the Occupational Health and Safety Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (MSS Res. 05, I-21)
Protecting Workers During Catastrophes: AMA-MSS will ask (1) that our AMA advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes and (2) that our AMA advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes. (MSS Res. 040, A-22)

Organ Donation and Transplantation

Organ Donors and Transplants: AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep ZZ, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12) (Reaffirmed: MSS GC Report A, I-17)

Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors: AMA-MSS will ask the AMA to support efforts to increase the number of all potential bone marrow donors, especially minority donors, registered in national bone marrow registries to improve the odds of successful HLA matching and bone marrow transplantation. (AMA Res 501, I-94 Adopted [H-370.974]) (Re reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Increasing Organ Donation Discussions through Medical Education: Our AMA-MSS will (1) encourage the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and the Liaison Committee on Medical Education to include training on organ donation discussions in undergraduate and graduate medical education; (2) ask the AMA to compile current materials into a comprehensive resource and make them available for the development of a Continuing Medical Education Activity educating physicians on how to conduct organ donation discussions with patients; and (3) ask the AMA to support the development of billing codes for physician-patient organ donation discussions. (MSS Res 9, I-11) (AMA Res 307, A-12 Not Adopted) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Investigating the Possibility of a Unified Living Donor Kidney Registry: AMA-MSS will encourage the AMA to support the study of how to develop a unified, nationwide living kidney donor registry and advocate for public and private funding of such studies to reach the long term goal of establishing a unified registry. (MSS Res 24, I-12) (AMA Res 2, A-13 Referred for Decision) (Reaffirmed: MSS GC Report A, I-17)

Organ Donation Education Programs in Driver Training Programs: AMA-MSS will ask the AMA to encourage all states to include organ and tissue donation education in pre-licensing and drivers training programs. (MSS Res 29, I-12) (Policy H-370.984 Adopted as Amended in Lieu of AMA Res 3, A-13) (Reaffirmed: MSS GC Report A, I-17)
370.013MSS Presumed Consent Organ Donation: AMA-MSS will ask the AMA to reexamine the ethical considerations of presumed consent and other potential models for increasing the United States organ donor pool. (MSS Res 1, I-13) (Reaffirmed: MSS GC Rep A, I-19)

370.014MSS Removal of Cannabis as a Relative Contraindication for Potential Organ Transplant: AMA-MSS opposes utilization of 1) reported marijuana use; and 2) positive cannabis toxicology tests as a relative contraindication for potential organ transplant recipients. (MSS Late Res 3, I-14) (Reaffirmed: MSS GC Rep A, I-19)

370.015MSS Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool: AMA-MSS will ask (1) that our AMA support the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation, (2) that our AMA support well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates, and (3) that our AMA seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (MSS Res 08, I-15 Immediate Transmittal to HOD) (AMA Res 007, I-15 Adopted) (Reaffirmed: MSS GC Rep B, A-21)


370.018MSS Protecting Equity in Access to Kidney Dialysis and Transplant and Advocating for Patients’ best Interest in End Stage Renal Disease: AMA-MSS supports evidence-based patient education and counseling regarding the relative risks and benefits of all treatment options for end-stage renal disease, including various types of dialysis and organ transplantation. (MSS Res 6, I-17)

370.019MSS Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease: AMA-MSS supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease. (MSS Res 08, A-18)

370.020MSS Improving Body Donation Regulation: AMA-MSS will ask the AMA to recognize the need for ethical, transparent, and consistent body and body part donation regulations. (MSS Res 11, I-18) (AMA Res 12 A-19, Adopted [H- 460.890])

370.021MSS Revising the Social Support Criterion of Organ Transplant Waitlist Eligibility: AMA-MSS supports revision of the adequate social support criterion used in organ transplantation eligibility determination and encourages standardized
evaluation of patients’ social support to enhance transparency and decrease discrimination in the field. (MSS Res. 16, I-19)

370.022MSS Encouraging Brain and Other Tissue Donation for Research and Educational Purposes: AMA-MSS will ask the AMA to: (1) support the production and distribution of educational materials regarding the importance or postmortem tissue donation for the purposes of medical research and education; (2) encourage the inclusion of additional information and consent options for brain and other tissue donation for research purposes on appropriate donor documents; (3) encourage all persons to consider consenting to tissue donation including brain tissue for research purposes; (4) encourage efforts to facilitate recovery of postmortem tissue including brain tissue for research and education purposes. (MSS Res. 77, I-19) (AMA Res. 521, Adopted as Amended {}, A-22)

370.023MSS Blood and Tissue Deferral Criteria: AMA-MSS: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and corneal tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and corneal tissue donation. (MSS Res. 034, A-21)

385.000MSS Physician Payment


385.002MSS The Patient-Centered Medical Home Concept: AMA-MSS will ask the AMA to (1) Adopt the following definition of the patient-centered medical home model as set forth by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association in the Joint Principles of the Patient-Centered Medical Home:
   (a) Personal physician
   (b) Physician directed medical practice
   (c) Whole person orientation
   (d) Care is coordinated and/or integrated
   (e) Quality and safety
   (f) Enhanced access
   (g) Payment;
(2) Continue to support the Medicare Medical Home Demonstration project and study the implications of including “payment” as a principle in the definition of the patient-centered medical home model; and (3) Advocate that

**390.000MSS Physician Payment: Medicare**


**390.004MSS Reimbursement Violations:** AMA-MSS will ask the AMA to urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution. (AMA Sub Res 705, A-93 Adopted [H-335.973]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep A, I-21)

**390.005MSS Opposing Medicare Reimbursement Based Off of Patient Satisfaction Score:** Our AMA-MSS will ask that our AMA study the potential healthcare disparities caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in Medicare reimbursement. (MSS Res 10, A-16) (Reaffirmed: MSS GC Report A, I-21)

**405.000MSS Physicians**

**405.002MSS National Service Project:** (1) AMA-MSS recognizes the value of associating the AMA-MSS with a community service project at each medical school. (2) AMA-MSS will make available a national service project that may be implemented at each medical school. (MSS Res 17, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


**405.006MSS Non-Compete Clauses in Physician Contracts:** AMA-MSS opposes the use of restrictive covenants in physician contracts and supports the passage of laws that prohibit their use. (MSS Res 56-I-17)
420.000MSS  Pregnancy

420.002MSS  Substance Abuse During Pregnancy: AMA-MSS will ask the AMA to: (1) continue its ongoing efforts to educate the general public, especially adolescents, about the effects of alcohol use disorder on prenatal and postnatal development and expand these efforts to target substance use disorders; and (2) encourage intensified research into the physical and psychosocial aspects of maternal substance use as well as the development of efficacious prevention and treatment modalities. (AMA Res 244, A-89 Adopted [H-420.976]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

420.003MSS  Nutrition Counseling for Pregnant and Recent Post-Partum Patients: AMA-MSS will ask the AMA to (1) support physician referrals of pregnant and recent post-partum patients to registered dietitians for nutrition counseling; and (2) advocate for the extension of health insurance coverage to registered dietician visits for all pregnant and recent post-partum patients. (MSS Res 31, I-10) (AMA Res 409, A-11 Adopted as Amended) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

420.005MSS  Inclusion of Folic Acid Supplements in the Supplemental Nutrition Program: AMA-MSS will ask the AMA to (1) support the addition of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs; and (2) work with United States Department of Agriculture and other appropriate organizations to encourage and procedurally facilitate the implementation of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs. (MSS Res 20, A-12) (Policy D-150.983, D-150.987, D-150.981, H-150.937, H-150.933, H-150.944, H-150.953, H-150.960, H-440.902 and D-440.954

420.006MSS  High Rates of Cesarean Deliveries: AMA-MSS will ask the AMA to (1) support the American Congress of Obstetricians and Gynecologists’ opinion that recommended vaginal delivery instead of cesarean section in the absence of maternal or fetal indications; and (2) encourage appropriate agencies and organizations to study the indications for cesarean section in order to achieve a greater degree of standardization in their use. (MSS Res 10, I-13) (AMA Res 706, A-14 Not Adopted) (Amended and Reaffirmed: MSS GC Rep A, I-19)

420.007MSS  Providing Complete Maternity Care Under the Affordable Care Act: AMA-MSS will ask the AMA to advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents’ large group plans. (MSS Res 13, I-13) (AMA Res 101, A-14 Adopted [H-185.997]) (Reaffirmed: MSS GC Rep A, I-19)
Advance Directives During Pregnancy: That our AMA-MSS ask our AMA to (1) support that pregnant women with decision-making capacity have the same right to refusal of treatment through advanced directives as non-pregnant women; and (2) study the legality and ethics related to the circumstances under which restrictions and/or exclusions are applied to pregnant women's advance directives. (MSS Res 25, A-14) (AMA Res 1, I-14 Referred) (Reaffirmed: MSS GC Rep A, I-19)

Infertility and Infertility Insurance Coverage: AMA-MSS (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons. (MSS Res 24-I-17)

Improving Minors’ Access to Prenatal and Pregnancy-Related Care: Our AMA-MSS supports the right of the minor to consent health care services from the prenatal stage through delivery, including but not limited to consenting to an epidural, a cesarean section, and testing for chromosomal abnormalities in the fetus. (MSS Res 25, A-18)

Support for the Standardization of Care for Postpartum Hemorrhage: AMA-MSS supports the standardization of care, and establishment of formal protocols for the management of postpartum hemorrhage. (MSS Res 09, I-18)

Amendment to Truth and Transparency in Pregnancy Counseling Centers: AMA-MSS will ask the AMA to amend policy H-420.954, Truth and Transparency in Pregnancy Counseling Centers to read:

H-420.954 – Truth and Transparency in Pregnancy Counseling Centers

1. Our AMA supports advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious association which such entities may have;

2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman’s pursuit of any medical services for the care of her unplanned pregnancy;

3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;

4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women.
Classification and Surveillance of Maternal Mortality: AMA-MSS will ask the AMA to (1) advocate for an annual release of the national maternal mortality rate in the United States and (2) collaborate with relevant stakeholders to advocate for a reliable, accurate, and standardized definition of maternal mortality that will be implemented across states for tracking data on maternal mortality. (MSS Res. 44, I-19)

Addressing Informal Milk Sharing: Our AMA-MSS will ask the AMA to: (1) discourage the practice of informal milk sharing when said practice does not rise to health and safety standards comparable to those of milk banks, including but not limited to screening of donors and/or milk pasteurization; (2) encourage breast milk donation to regulated human milk banks instead of via informal means; and (3) support further research into the status of milk donation in the U.S. and how rates of donation for regulated human milk banks may be improved.

(MSS Res. 033, Nov. 2020) (AMA Res. 520, Adopted as Amended with Title Change [], A-22)

Protections for Incarcerated Mothers to Breastfeed and/or Breast Pump: Our AMA-MSS will ask the AMA to amend policy H-430.990, by addition to read as follows:

BONDING PROGRAMS FOR WOMEN PRISONERS AND THEIR NEWBORN CHILDREN, H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA supports policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance use problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
420.017MSS  
**Opposition to the Criminalization of Perinatal Demise:** Our AMA-MSS opposes the criminalization of perinatal loss in women who experience known medical conditions, including addiction or other mental health disorders during pregnancy.  
(MSS Res. 069, Nov. 2020)

420.018MSS  
**Hospital Bans on Trial of Labor after Cesarean:** Our AMA-MSS will ask the AMA to: (1) encourage hospitals that can provide basic maternal care as defined by the American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC) and (2) encourage hospitals that do not have resources to perform trial of labor after cesarean (TOLAC) to assist in the transfer of care patients who desire TOLAC to a hospital that is equipped to perform TOLAC.  
(MSS Res. 128, Nov. 2020)

420.019MSS  
**Increasing Support for Doula Services to Reduce Maternal Mortality:** AMA-MSS supports Medicaid coverage for doula services.  
(MSS Res. 011, A-21)

420.020MSS  
**Access to Standard Care for Non-Viable Pregnancy:** AMA-MSS opposes any hospital directive, policy, or legislation that may hinder patients’ timely access to the accepted standard of care in both emergent and non-emergent cases of non-viable pregnancy.  
(MSS Res. 059, A-21)

420.021MSS  
**Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid:** AMA-MSS will ask the AMA to amend Policy D-290.974, Extending Medicaid Coverage for One Year Postpartum, by addition as follows:

D-290.974 – Extending Medicaid Coverage for Pregnancy One Year Postpartum

1. Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and
2. Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnancy and postpartum for non-citizen immigrants.  
(MSS WIM CEQM Report A, A-21)  
AMA Res. 701, I-21, Adopt as Amended [D-290.974])

420.022MSS  
**Access to Naloxone for Vulnerable and Underserved Populations:** AMA-MSS will ask that the AMA amend Policy H-420.950, “Substance Use Disorders During Pregnancy” by addition and deletion to read as follows:

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected, and (5) that our AMA support universal opioid use screenings at prenatal care visits with
early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits. (MSS WIM Report A, A-22)

435.000MSS Professional Liability

435.004MSS 
A No-Fault Professional Liability System: AMA-MSS will ask the AMA to encourage state-based demonstration projects of a no-fault medical professional liability system as the preferred mechanism for improving patient safety, efficiently compensating injured patients, and reducing the substantial costs of defensive medicine and litigation to our healthcare system. (MSS Res 28, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

435.007MSS 
U.S. Medical Liability Crisis and the Impact on Clinical Medical Education: AMA-MSS will ask the AMA to: (1) recognize that undergraduate and graduate medical education are impacted by the medical liability crisis; and (2) oppose medical liability insurance premiums based solely on preceptor or volunteer faculty status (MSS Res 5, A-04) (AMA Res 909, I-04) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

435.008MSS 
Error Disclosure and Physician Apologies: AMA-MSS supports (1) full disclosure of medical errors; and (2) legislation that allows a physician to make an expression of apology, regret, sympathy, commiseration, condolence, or compassion to a patient or a patient’s family without it constituting an admission of physician liability for any purpose. (MSS Res 6, A-07) (Reaffirmed: GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

435.009MSS 
Liability Coverage for Medical Students Completing Extramural Electives: (1) AMA-MSS will (a) encourage the Association of American Medical Colleges to increase the utility of its Extramural Electives Compendium (EEC) by providing information regarding liability coverage requirements at all host institutions and by making this a searchable feature, and additionally that the AMA-MSS provide a link to the EEC on its Web site; and (b) take into account the appropriate minimum levels of student liability coverage when examining the issue of student debt, particularly when in conversations with the administrations of various medical schools; and (2) AMA-MSS will ask the AMA to (a) take into account the appropriate minimum levels of student liability coverage when examining the issue of student debt, particularly when in conversations with the administrations of various medical schools; (b) examine whether or not students have been found partially accountable in recent malpractice suits, as well as the appropriateness of the amounts of medical student liability coverage required by medical schools with respect to the current medical professional liability insurance market; and (c) examine the propriety of schools requiring their own and visiting students to carry levels of medical liability coverage in excess of the minimum amounts mandated for physicians by state law. (MSS Rep C, A-08) (AMA Res 913 Referred) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)
Quantifying Medical Tort Reform: (1) AMA-MSS supports medical liability reform at the federal, state, and municipal levels including, but not limited to, non-economic damage caps, collateral source offset provisions, and the implementation of malpractice courts; (2) AMA-MSS will ask the AMA to study the true costs of defensive medicine and the financial impact that tort reform would have on the entire health care system, with a report back and to be updated every ten years. (MSS Res 15, I-09) (AMA Res 216, I-09 Adopted [D-435.973]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)
440.000MSS  Public Health

440.001MSS  Qualifications of the Surgeon General: AMA-MSS will ask the AMA to: (1) endorse the concept that the Surgeon General of the United States should have substantial experience or training in public health; and (2) oppose any nominations for the position of U.S. Surgeon General of persons without such background. (AMA Res 154, A-81 Not Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

440.002MSS  Immunization Programs for Children: AMA-MSS will ask the AMA to: (1) support domestic and international immunization programs; (2) develop legislation to ensure the priority of these programs; and (3) urge more intensive research to develop improved vaccines and immunization technology. (AMA Amended Res 63, I-82 Adopted [H-440.991]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


440.006MSS  Ocular Sun Damage to the Retina and its Prevention: AMA-MSS will ask the AMA to: (1) support efforts to educate the general public about the potential long term effects of sun and bright light exposure, and the possible benefit derived from wearing protective eyewear blocking out radiation of wavelengths of less than 500 nm in preventing AMA; and (2) incorporate this issue into existing health education efforts. (AMA Res 12, A-91 Referred) (BOT Rep T, I-91 Filed) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
440.007MSS  **Lead Based Paints:** AMA-MSS will ask the AMA to: (1) promote community awareness of the hazard of lead based paints; and (2) urge paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold. (AMA Res 420, I-91 Adopted [H-440.943]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-440.943 Rescinded: CCB/CLRPD Rep. 3, A-14) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

440.008MSS  **Tuberculosis Resurgence and Physician Awareness:** AMA-MSS will ask the AMA to: (1) work with the Centers for Disease Control (CDC) to educate physicians and the public on the recent resurgence and unusual presentations of tuberculosis; and (2) work with the CDC to promote improved methods of screening, treatment, and prevention of further transmission of tuberculosis. (AMA Res 404, A-92) (BOT Amended Rep OO, A-92, Adopted in Lieu of Res 404 and 407 [H-440.938]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS Res 27, A-14) (Reaffirmed: MSS GC Rep A, I-19)


440.013MSS  **Obesity as a Chronic Disease:** AMA-MSS will ask the AMA to: (1) recognize childhood and adult obesity as a major public health problem; and (2) work with other public and private organizations to develop ethical and evidence-based recommendations regarding education, prevention, and treatment of obesity. (MSS Amended Sub Res 33, A-98) (AMA Amended Res 423, A-98 Adopted [H-440.902]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

440.017MSS  **Reducing the Risk of Flight-Associated Venous Thromboembolism:** AMA-MSS will ask the AMA to work with and encourage the Federal Aviation Administration (FAA) and the airline industry to alert passengers to the flight-associated risk of deep vein thrombosis and to provide specific recommendations to passengers regarding ways to reduce their flight-associated risk for DVT. (MSS Res 3, A-02) (AMA Res 406, A-03 Referred) (CSA Rep 4, A-04 Adopted [D-45.998]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

440.018MSS  **Childhood Obesity as a Public Health Epidemic:** AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and

440.019MSS Requirement for Daily Free Play in Schools: AMA-MSS will ask the AMA to:
(1) recommend that elementary schools maintain at least thirty minutes of daily free play during each school day; and (2) work with other interested medical societies to urge the Department of Education and state and national legislatures to enact regulatory and legislative provisions that ensure at least thirty minutes of daily free play for elementary school students. (MSS Res 20, I-03) (AMA Amended Res 409, A-04 Adopted [H-470.961 and D-470.994])

440.020MSS Support for Needlestick Prevention: AMA-MSS strongly supports the implementation of needlestick prevention devices, including but not limited to retractable needles or needleless systems, with the participation of physicians and other health care workers who will use such devices and, where appropriate, the introduction of such devices accompanied by the necessary education and training as part of a comprehensive sharps injury prevention and control program. (MSS Res 29, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

440.021MSS Promoting Fitness and Healthy Lifestyles: AMA-MSS encourage all physicians and health professionals to set an example by (1) striving to maintain a healthy weight and engaging in physical activity as recommended by scientific literature and expert panels; (2) maintaining a healthy and nutritious diet as recommended by scientific literature and expert panels; and (3) getting enough sleep to avoid the known short and long term adverse effects of sleep deprivation as recommended by scientific literature and expert panels. (MSS Res 28, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS Res 41, I-16) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


440.024MSS Advertising for Herbal Supplements: AMA-MSS will and will ask the AMA to: (1) strongly encourage the naming of herbal supplements in a manner so that they cannot be confused with prescription drugs; (2) strongly discourage the advertising of herbal supplements in a way that resembles prescription drug advertisements; (3) work with the appropriate agencies to strengthen regulations regarding the advertising and distribution of herbal supplements and work with appropriate agencies to improve public awareness of regulations and distribution practices associated with herbal supplements, including but not limited to purity, safety, and pregnancy risk. (MSS Res 38, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)
440.025MSS Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes: AMA-MSS will ask the AMA to: (1) encourage the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) support referring those seeking a driver's license who fail a vision screening at their respective Department of Motor Vehicles to an appropriate healthcare provider for a complete dilated eye exam and information about free health coverage programs when necessary or applicable. (MSS Res 16, A-05) (AMA Amended Res 813, I-05 Adopted [H-25.990]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

440.026MSS Urging the Establishment of a Federal Office of Men’s Health: AMA-MSS will ask the AMA to promote the establishment of a federal Office of Men’s Health to coordinate outreach and awareness efforts on the federal and state levels, promote preventive health behaviors for men, and provide a vehicle whereby researchers on men’s health can collaborate and share information and findings. (MSS Res 18, A-05) (AMA Res 706, I-05 Not Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

440.027MSS Increasing Accessibility to Meningitis Protection: (1) AMA-MSS will encourage all universities to offer the meningococcal vaccine preferably at reduced cost and to educate students about the benefits of vaccination. (2) AMA-MSS supports the incorporation of the cost of the meningococcal vaccine into the estimated cost of attendance. (MSS Res 17, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

440.029MSS Usage of Alcohol Based Hand Sanitizers in Institutional Settings: AMA-MSS: (1) recognizes alcohol-based hand sanitizers with alcohol concentrations of greater than 60% as an effective adjunct to hand washing in reducing microbial contamination and spread; and (2) urges the placement of alcohol-based hand sanitizer dispensers in institutional settings and highly trafficked public areas. (MSS Res 9, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

440.032MSS Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance: AMA-MSS will ask the AMA to work with interested partners in the Federation of Medicine to develop formal recommendations, based on a review of the evidence and expert clinical judgment, to develop and/or improve new or existing FDA guidelines concerning the prudent use of antibiotics in livestock to protect patients from the dangers of antimicrobial-resistant pathogens. (MSS Res 1, A-08) (AMA Res 530, A-08 Adopted as Amended [D-100.976]) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

440.033MSS Placement of Alcohol-Based Hand Sanitizer Dispensers Outside of Public Restrooms: AMA-MSS will ask the AMA to (1) recognize alcohol-based hand sanitizers with alcohol concentrations greater than 60 percent as an effective adjunct to hand washing in reducing microbial contamination and spread; and


440.035MSS Increasing Advocacy for and Public Awareness of the Lack of a Vaccine- Autism Link: AMA-MSS will ask the AMA to ask the Office of the Surgeon General for a definitive repudiation of the link between developmental disorders, such as autism, and either thimerosol-containing vaccines or the MMR vaccine. (MSS Res 24, I-09) (AMA Res 413, A-10 Adopted [H- 440.853]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)


440.037MSS AMA-MSS Support for FDA Efforts to Reduce Computed Tomography Radiation in Children: AMA-MSS (1) supports the current US Food and Drug Administration policy including; promoting the safe use of medical imaging devices, supporting informed clinical decision making and increasing patient awareness; (2) supports working with all relevant parties to advocate for inclusion of an individual registry containing the patient’s historical (test and procedure-based) cumulative radiation dose, as well as research the fiscal impact such a registry would incur; (3) encourages the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving and that will help physicians discuss the potential dangers of high level of radiation exposure with patients; and (4) supports initiatives to increase awareness of ionizing radiation exposure from medical imaging and practices that lower radiation exposure from medical imaging. (MSS Res 41, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Support for Service Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership: AMA-MSS will ask the AMA to (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit. (MSS Res 45, I-11) (Reaffirmed: MSS GC Report A, I-16) (Modified: MSS Res 12, I-16) (AMA Res 508, A-17 Referred)

Increased Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment: AMA-MSS will ask the AMA to (1) encourage the adoption of age-based screening practices for hepatitis C, in alignment with recent Centers for Disease Control recommendations; and (2) to encourage increased resources for Centers for Disease Control and state Departments of Public Health for the development and coordination of Hepatitis C Virus infection educational and prevention efforts. (Sub MSS Res 45, A-12) (Reaffirmed: MSS GC Rep A, I-19)

Accounting for Socioeconomic Status in Clinical and Public Health Research: AMA-MSS will ask the AMA to study the literature regarding the inclusion of socioeconomic status data in clinical and public health research so as to recommend future inclusion of appropriate minimum standards. (MSS Res 15, I-12) (Amended AMA Res 502, A-13 Adopted) (Reaffirmed: MSS GC Report A, I-17)

Permitting Sunscreen in Schools: AMA-MSS will ask the AMA to (1) support the exemption of sunscreen from over-the-counter medication possession bans in schools and to encourage all schools to allow students to bring and possess sunscreen at school without restriction; and (2) encourage schools to allow teachers to provide students with sunscreen, without requiring the teacher to assist in application. (MSS Res 18, I-12) (Amended AMA Res 403, A-13 Adopted [H-460.980]) (Reaffirmed: MSS GC Report A, I-17)

Promoting Celiac Disease Screening Usage and Standards: AMA-MSS (1) recognizes undiagnosed celiac disease as a public health problem; and (2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders. (MSS Res 14, A-13) (Reaffirmed: MSS GC Rep A, I-19)

Sunscreen and Sun Protection Counseling by Physicians: AMA-MSS will ask the AMA to encourage physicians to counsel their patients on sub-protective behavior. (MSS Res 26, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Development of a Standardized Post-Conducted Electrical Devise Exposure Medical Protocol and Educational Campaign: AMA-MSS will ask the AMA to (1) encourage appropriate organizations and medical specialty societies to develop a standardized, post-exposure medical protocol for the use of conducted electrical devices (CEDs) using recent advances in the understanding of the risks associated with CEDs; and (2) support the
incorporation of a standardized post-conducted electric device (CED)- exposure medical protocol into law enforcement procedures and training. (MSS Res 28, I-13) (Reaffirmed: MSS GC Rep A, I-19)

440.046MSS  Prevention of Mosquito-Transmitted Diseases: AMA-MSS will ask the AMA to encourage physicians to discuss and promote protective practices specific for mosquitoes, such as those developed by the Centers for Disease Control, with patients when clinically appropriate. (MSS Res 36, I-13) (Reaffirmed: MSS GC Rep A, I-19)

440.048MSS  Eradicating Homelessness: AMA-MSS will ask the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. (MSS Res 33, A-14) (Reaffirmed: MSS GC Rep A, I-19)

440.049MSS  Labeling and Recommended Protection for Sunglasses: AMA-MSS will ask the AMA to: (1) recognize based on current evidence that sunglasses that protect against 100% of both UVA and UVB radiation are currently the safest choice for consumers; and (2) recommend that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation reflected so that consumers know the extent to which the glasses protect against both types of UV radiation. (MSS Res 17, I-14) (Reaffirmed: MSS GC Rep A, I-19)

440.050MSS  Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes: AMA-MSS will ask the AMA to: (1) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; and (2) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation. (MSS Res 28, I-14) (AMA Res 202, A-15 Referred) (Reaffirmed: MSS GC Rep A, I-19)

440.051MSS  A Comprehensive Education Strategy to Improve Vaccination Rates: AMA-MSS (1) supports national, evidence-based education of parents by clinicians and reputable public health organizations about the risks and benefits of immunization to both children and the community at large to combat the public health threat that under-immunization poses; (2) supports the development of resources for physicians aimed at improving patient education regarding the safety of vaccines, their effectiveness at preventing communicable diseases, and the importance of maintaining herd immunity; and (3) will ask the AMA to partner with appropriate stakeholders to sponsor a national, evidence-based public service announcement campaign aimed at increasing the vaccination rate. (MSS Res 4, A-15) (Recommendations in CSAPH Rep 1 Adopted as Amended in Lieu of AMA Res 904, I-15) (Reaffirmed: MSS GC Rep B, A-21)

440.052MSS  Support for Municipal Ordinances that Promote Green Space in Residential Zoning Districts: AMA-MSS ask the AMA to support appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients’ health and eliminate health
Support for Mandatory Vaccination: AMA-MSS (1) asks the AMA to reaffirm policy H-440.970; (2) encourages schools to report student vaccination rates and exemption rates to parents and guardians prior to annual student enrollment; and (3) supports the establishment of national vaccine requirements for minors. (MSS Res 21, A-15) (Reaffirmed: MSS GC Rep B, A-21)


Oil and Gas Well-Stimulation Disclosure and Moratorium: AMA-MSS supports legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil, and gas exploration and extraction. (MSS Res 48, A-15) (Reaffirmed: MSS GC Rep B, A-21)

Radon Testing in Rentals: AMA-MSS will ask that our AMA support transparency and disclosure in prior radon testing, the most recent results of such testing, prior mitigation or remediation efforts, and other relevant information to protect renters and tenants when entering into a lease. (MSS Res 25, I-15) (Amended Policy H-455.986 Adopted in Lieu of AMA Res 505, A-16) (Reaffirmed: MSS GC Rep B, A-21)

Improving Detection, Awareness, and Prevention of Lead Contamination in Water: (1) Our AMA-MSS supports future research to improve water sampling techniques and protocols to better detect human exposure to lead at the point of consumption; (2) Our AMA-MSS supports improved open public access to testing data on health hazardous substance levels in public commodities, such as water; and (3) Our AMA-MSS supports legislation and efforts to reduce or eliminate lead from public and private water infrastructure. (MSS Res 23, A-16) (Reaffirmed: MSS GC Report A, I-21)

Importance of Oral Health in Medical Practice: AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support efforts to increase access to oral health services. (MSS Res 22, I-16) (Reaffirmed: MSS GC Report A, I-21)

Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals: The AMA-MSS (1) supports hepatitis C virus (HCV) treatment programs aimed at
reducing the public health burden of the HCV epidemic; (2) will ask that our AMA support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV, particularly those providers serving rural or otherwise underserved populations; and (3) will ask that our AMA amend current policy H-440.845 by addition to read as follows:

**Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845**

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.

(MSS Res 28, I-16) (AMA Res 410, A-17 Adopted as Amended [H-440.845])
(Reaffirmed: MSS GC Report A, I-21)

**440.060MSS** Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States: AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows:

**Eradicating Homelessness H-160.903**

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.


**440.061MSS** Expanding Expedited Partner Therapy to Treat Trichomoniasis: AMA-MSS will ask that our AMA amend policy H-440.868 by addition and deletion as follows:
Expedited Partner Therapy H-440.868
Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, and/or chlamydia, and/or trichomoniasis infection.

(MSS Res 03, A-17)

440.062MSS Addressing Foster Care Healthcare Needs: AMA-MSS will ask that our AMA advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children. (MSS Res 17, A-17)

440.063MSS Recognizing Poverty-Level Wages as a Social Determinant of Health: AMA-MSS (1) declares poverty-level minimum wages a negative social determinant of health; and (2) supports efforts that address poverty level wages to alleviate their role as a negative social determinant of health. (MSS Res 37, A-17)

440.064MSS Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data: AMA-MSS will ask the AMA to (1) oppose policies that enable racial housing segregation and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. (MSS Res 12, I-17)

440.065MSS Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic: AMA-MSS will ask the AMA to 1) acknowledge HPV Vaccines as beneficial to all genders as anti-cancer and anti-STI; and (2) support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs. (MSS Res 15-I-17)

440.066MSS Opposition to Measures That Criminalize Homelessness: AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; and (2) advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights. (MSS Res 20-I-17)

440.067MSS Food and Drug Administration Conflict of Interest: AMA-MSS will ask the AMA to (1) advocate for a reduction of conflict of interest waivers graded to Advisory Committee Candidates, and (2) advocate the Food and Drug Administration place a greater emphasis on candidates’ conflict of interest when selection members for advisory committees (MSS Res 18-I-17)

440.068MSS Support for Public Health Violence Prevention Programs: AMA-MSS will ask the AMA to support legislation in addition to other mechanisms that encourage the development and use of evidence-based public health models that prevent violence. (MSS Res 78-I-17)

440.069MSS Increased Access to Identification Cards for the Homeless Population: AMA-MSS will ask the AMA to (1) recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as fundamental
services that support healthy lifestyle; (2) support legislation and policy changes that aim to provide a streamlined and simplified application process for obtaining identification cards that facilitate accessibility to the homeless population; and (3) promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge. (MSS Res 27, A-18)

**440.070MSS** Increasing Availability of Bleeding Control Supplies: AMA-MSS will ask the AMA to amend Policy H-130.935 by addition as follows:

**H-130.935: Support for Hemorrhage Control Training**

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.

2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.

(MSS Res 27, I-18) (AMA Res 527, A-19, Adopted as amended [H-130.935])

**440.071MSS** Improving the Health and Safety of Consensual Sex Workers: AMA-MSS will ask the AMA to (1) recognize the adverse health outcomes of criminalizing consensual sex work; (2) support legislation that decriminalizes individuals who exchange sex for money or goods; (3) oppose legislation that decriminalizes sex buying and brothel keeping; (4) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors; and (5) support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (MSS Res 05, A-19) (Appended: MSS CGPH Report A, I-19) (AMA Res. 010, Adopt as Amended with Title Change [H-65.948], A-22)

**440.072MSS** Sunscreen Dispensers in Public Spaces as a Public Health Measure: AMA-MSS will ask the AMA to support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure. (MSS Res 28, A-19) (MSS Res. 905, Adopt as Amended [H-440.839], I-19)

**440.073MSS** Increasing Access to Gang-Related Tattoo Removal in Prison and Community Settings: AMA-MSS will ask the AMA to support increased access to gang-related tattoo removal in prison and community settings. (MSS Res 31, A-19) (MSS Res. 907, Adopt as Amended with Title Change “Increased Access to Removal of Gang-Related and Human Trafficking-Related Tattoos in Correctional and Community Settings” [H-440.812], I-19)

**440.074MSS** The Effects of Employment Discrimination on the Health of Formerly Incarcerated Individuals: AMA-MSS supports policies and practices that prevent employers from discriminating against formerly incarcerated individuals. (MSS Res 34, A-19)

**440.075MSS** Support for Research of Boxes for Babies Sleeping Environment: AMA-MSS will ask the AMA to support the research of safe sleeping environment programs, which could include the study of the safety and efficacy of boxes for
babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States. (MSS Res 13, I-17)

440.076MSS Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing: AMA-MSS will ask the AMA to support research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence. (MSS Res 46, A-18) (AMA Res 528, A-19, Adopted [H-60.990])

440.077MSS Compassionate Release for Incarcerated Patients: AMA-MSS will ask the AMA to (1) support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; (2) collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and (3) promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. (MSS Res 04, I-18) (AMA Res 430, A-19, Referred) (Adopted BOT Rep. 10, I-20 [H-430.980])

440.078MSS Support for Universal Basic Income Pilot Studies: AMA-MSS will ask the AMA to support federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants. (MSS Res 19, I-18) (AMA Res 236, A-19, Referred) (Adopted, CMS Rep. 03, A-21 [ ])

440.079MSS Medical Respite Care for Homeless Adults: AMA-MSS will ask the AMA to study funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (MSS Res 42, I-17) (AMA Res 416, A-18, Appended [H-160.903])

440.080MSS Ending Money Bail to Decrease Burden on Lower Income Communities: AMA-MSS will ask the AMA to support legislation that ends pre-trial financial release options for individuals charged with non-violent crimes. (MSS Res 55, I-17) (AMA Res 408, A-18, Adopted [H-80.993])

440.081MSS Adverse Impacts of Delaying the Implementation of Public Health Regulations: AMA-MSS will ask AMA to 1) examine the feasibility of filing an amicus brief highlighting the detrimental health effects of municipal solid waste landfill pollution in Court Case #18-cv-03237 (State of California et. Al v EPA et. Al); 2) amend H-135.950 Support the Health-Based Provisions of the Clean Air Act to Read as follows:

Support the Health-Based Provisions of the Clean Air Act, H-135.950

Our AMA (1) opposes changes to the New Source Review Program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; (3) opposes further legislation, rules, and regulations that weakens the existing provisions of the Clean Air Act; and (4) support updates to the Risk Management Program such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public;
3) recognize the significant health risks associated with pesticide exposure; 4) urge the EPA and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children; and 5) analyze ongoing regulation delays that impact public health, as deemed appropriate. (MSS CGPH Rep A, I-18) (AMA Res 529, Adopted as Amended [D-440.925])

440.082MSS Recognizing Loneliness as a Public Health Issue: AMA-MSS will ask the AMA to: (1) release a statement identifying loneliness as a public health issue with consequences for physical and mental health; and (2) support evidence-based efforts to combat loneliness. (MSS Res. 09, I-19) (AMA Res. 432, Adopted [], A-22)

440.083MSS Advancing the Role of Outdoor Recreation in Public Health: AMA-MSS will ask the AMA to: (1) encourage federal, state, and local governments to create new and maintain existing public lands and outdoor spaces for those purposes of outdoor recreation; and (2) work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to encourage continued research on the clinical uses of outdoor recreation therapy. (MSS Res. 20, I-19) (AMA Res. 230, Adopted as Amended [], A-22)

440.084MSS Advocating for the Amendment of Chronic Nuisance Ordinances: AMA-MSS will ask the AMA to: (1) advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services are not counted towards nuisance designations; and (2) support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of disparities. (MSS Res. 25, I-19) (AMA Res. 412, Adopted [], A-22)

440.085MSS Urban Forestry as Public Health Infrastructure: AMA-MSS (1) recognizes the positive impact of urban forestry on air quality and related respiratory conditions, and the need for state and national policy to expand funding for urban tree-planting and maintenance programs and (2) acknowledges urban forestry as public health infrastructure in recognition of the public health and biophysical benefits of urban forestry-related programs. (MSS Res. 26, I-19)

440.086MSS Hepatitis A Screening for At-Risk Populations: AMA-MSS supports research into methods of containing and preventing future Hepatitis A outbreaks. (MSS Res. 66, I-19)

440.087MSS Restricting Use of Force by Law Enforcement Officers for Improved Public Health Outcomes: AMA-MSS will ask the AMA 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. (MSS Res. 68, I-19)

440.088MSS Amending D-440.847, to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles: Our AMA-MSS will ask the AMA to amend policy D-440.847 by addition and deletion as follows:

PANDEMIC PREPAREDNESS FOR INFLUENZA, D-440.847
In order to prepare for a potential influenza pandemic, our AMA:

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

2. Urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile, and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, and anti-viral microbial drugs, medical supplies, and personal protective equipment, and to continue the 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; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to, and protect the population from illness and death in an influenza 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 the tribal communities and the Indian Health Service to 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 influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

6. Supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct
patient contact, receive any appropriate vaccination 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 providers;

7. Will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plant to equitably respond to an influenza pandemic in the United States.

(MSS Res. 004, Nov. 2020) (HOD Res. 415, A-21 [ ])

440.089MSS

**Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional Facilities:** Our AMA-MSS will ask the AMA to: 1) collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious pathogens in the setting of prisons and jails, including, but not limited to: a) universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated; b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies; c) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens; d) Adherence to use of personal protective equipment for incarcerated individuals and staff; and e) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths; 2) support efforts to de-carcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious pathogens within correctional facilities and communities; and 3) support prioritizing COVID vaccine access for justice involved populations.

Our AMA-MSS will ask the AMA to amend policy H-430.989 by insertion as follows:

**DISEASE PREVENTION AND HEALTH PROMOTION IN CORRECTIONAL INSTITUTIONS, H-430.989**

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis, and highly contagious infection diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning
individuals to drug treatment programs as a sentence or in connection with sentencing.  
(MSS Res. 005, Nov. 2020) (Combined with AMA Res. 404 and Adopted)

440.090MSS Representation of Dermatological Pathologies in Varying Skin Tones: Our AMA-MSS will ask the AMA to: (1) Encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation; (2) Encourage the development of educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones; and (3) Support the overrepresentation of darker skin tones in dermatologic medical education materials.  
(MSS Res. 007, Nov. 2020) (AMA Res. 414, I-21, Alt. Res. 505 be Adopted in Lieu of [H-295.853])

440.091MSS Protestor Protections: Our AMA-MSS will ask the AMA to: (1) advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States and (2) encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm.  

440.092MSS Policing Reform: Our AMA-MSS will ask the AMA to: (1) recognize police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) 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; (3) advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct; (4) support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons; (5) advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; (6) advocate for the prohibition of the use of sedative/hypnotic agents, such as ketamine, by first responders for non-medically indicated, law enforcement purposes; (7) advocate for legislation and regulations which promote trauma-informed, community-based safety practices; and (8) support the creation of independent, third party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence.  
Our AMA-MSS supports advocating for the prohibition of issuance and execution of no-knock warrants.  
(MSS Res. 012, Nov. 2020) (AMA Res. 410., Adopted R1, 2, 5, 7 and R3, 4, 6, 8 Referred for Study, Nov. 2020)

440.093MSS Support for the Establishment of Medical-Legal Partnerships: Our AMA-MSS supports the expansion and development of medical-legal partnerships to better address social determinants of health.  
(MSS Res. 040, Nov. 2020)
Opposition to Medical Bonding in Jail: Our AMA-MSS supports advocating against prisoners’ release on bond when used to abdicate responsibility for incarcerated populations’ healthcare. (MSS Res. 041, Nov. 2020)

Supporting Measures to Ensure Safe Indoor Home Temperatures: Our AMA-MSS supports environmentally conscious efforts aimed at providing safe indoor temperatures including but not limited to more efficient weatherization, income-based subsidies, and/or seasonal termination protections to mitigate poor health outcomes for at-risk populations. (MSS Res. 047, Nov. 2020)

Support for Vote by Mail:
(1) Our AMA-MSS will ask the AMA to support measures to reduce crowding at polling locations and facilitates equitable access to voting for all voters, including: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail in ballot postage that is free or prepaid by the government; and (e) adequate resourcing of the United States Postal Service and election operational procedures; and (f) improving accessible voting measures for hospitalized patients.
(2) Our AMA-MSS will ask the AMA to oppose requirements for votes to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (MSS Res. 048, Nov. 2020) (HOD Res. 416 – Not Considered, Nov. 2020) (MSS Res 02, Adopt as Amended with Title Change: Support for Safe and Equitable Access to Voting) (MSS Res. 002, A-22, Adopt as Amended)

Support for Eviction and Utility Shut-off Moratoriums during Public Health Emergencies: Our AMA-MSS will ask the AMA to (1) advocate for policies that prevent evictions during public health emergencies and (2) advocate for prevention of termination of life-essential utilities during public health emergencies. (MSS Res. 058/073, Nov. 2020) (AMA Res. 411, Adopt as Amended with Title Change: Support for the Prevention of Eviction and the Termination of Life-Essential Utility Services during Public Health Emergencies)

Support Distribution of Free Hearing Protection in Relevant Public Venues: Our AMA-MSS supports the availability of free hearing protection, such as foam earplugs, in public spaces where noise levels exceed 85 dBA, such as bars and live music venues. (MSS Res. 110, Nov. 2020)

Support for Universal Internet Access: Our AMA-MSS will ask the AMA to amend policy H-478.980, Increasing Access to Broadband Internet to Reduce Health Disparities, by addition and deletion as follows:

INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES, H-478.980

1. Our AMA recognizes internet access as a social determinant of health and will advocate for universal and affordable access to the expansion of broadband and high-speed wireless internet and voice connectivity, especially in all rural and underserved areas of the United States while at all times taking care
to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

2. Our AMA advocate for federal, state and local policies to support infrastructure that reduces the cost of broadband and wireless connectivity and covers multiple devices and streams per household.

(MSS Late Resolution 001, Nov. 2020) (HOD Res. 217, Nov. 2020 – Not Considered)

440.100MSS Use of Non-Police Mental Healthcare Worker Teams to Respond to Appropriate 911 Calls: AMA-MSS supports the expansion and funding of non-police emergency behavioral health specialists and/or co-behavioral health specialists and police officer emergency dispatch teams where appropriate, and in compliance with the non-police team’s standards for team safety, to respond to mental health crisis calls.

(MSS Res 004, A-21)

440.101MSS Advocating for the Elimination of Hepatitis C Treatment Restrictions: AMA-MSS will ask the AMA to amend Policy H-440.845, Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment, by addition and deletion as follows:

Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment, H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with the Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC, Indian Health Service, and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) advocate, in collaboration with state and specialty medical societies as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payors; (45) support programs aimed at training providers in the treatment and management of patients infected with HCV; (56) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (67) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (78) encourage equitable reimbursement for those providing treatment; (9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions.

(MSS Res. 005, A-21) (Amended, MSS Res. 12, I-21) (AMA Res. 216, Adopted as Amended [], A-22)

440.102MSS Protection of Medical Students that Advocate Social Justice: AMA-MSS: (1) supports a physician-in-training’s First Amendment right to express opinions relating to medical issues; (2) opposes any institutional actions or policy that prevent or limit physician-in-training’s availability to advocate on behalf of patients’ interests or on behalf of good patient care, including direct or indirect institutional retaliation or disciplinary action; (3) encourages medical schools to explicitly enumerate policy pertaining to permitted student participation in lawful movements/protests within student conduct codes; and
(4) encourages medical schools and residency programs to blind applications to exclude arrests related to social justice movements and protests.
(MSS Res. 014, A-21)

440.103MSS  
Poverty-Level Wages and Health: AMA-MSS will ask the AMA to support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty.
(MSS Res. 015, A-21) (AMA Res. 203, I-21, Refer for Study)

440.104MSS  
Supporting the Further Study of Category III Sunscreen Ingredients: AMA-MSS supports the study of the health effects of sunscreen ingredients currently available in the United States which have not been determined to be generally recognized as safe and effective.
(MSS Res. 061, A-21)

440.105MSS  
Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants: AMA-MSS will ask the AMA to amend D-440.985, Health Care Payment for Undocumented Persons by addition as follows:

Health Care Payment for Undocumented Persons, D-440.985
Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level; and (2) supports methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces.
(MSS Res. 072, A-21)

440.106MSS  
Medical Misinformation in the Age of Social Media: AMA-MSS will ask the AMA to:
(1) encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourage social media organizations to recognize the spread of medical 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; (3) continue to support the dissemination of accurate medical information by public health organizations and health policy experts; (4) 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 information; (5) amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

An Urgent Initiative to Support COVID-19 Vaccination Information Programs, D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information programs by: (1) education 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, 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 vaccinations; (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;

(6) 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.

(MSS Late Res. 02, A-21, Immediate Forward) (HOD Res. 421, A-21, Adopt as amended, clause 6 Referred for Decision [X-XXX])

440.107MSS Investigation of Naturopathic Vaccine Exemptions: AMA-MSS will ask the AMA to oppose medical vaccine exemptions by non-physicians by amending H-440.970, Non-Medical Exemptions from Immunizations as follows:

Non-Medical Exemptions from Immunizations, H-440.970
1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.
Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal on nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations from ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated pediatric immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.
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(MSS CGPH Report B, A-21) (AMA Res. 207, I-21, Adopt as Amended with Title Change [H-440.970])

440.108MSS Regulation of Phthalates in Adult Personal Sexual Products: AMA-MSS will ask the AMA to amend Policy H-135.945 by addition and deletion as follows:

Encouraging Alternatives to PVC/Phthalate DEHP Products in Health, H-135.945

Our AMA:
(1) Encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available;
(2) Urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing phthalates such as DEHP;
(3) Encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal consumer products, including adult personal sexual products, as a source of phthalates; and
(4) Supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.
(MSS CSI COLA Report A, A-21)

440.109MSS Supporting Daylight Savings Time as the New, Permanent Standard Time: AMA-MSS will ask the AMA to: (1) recognize the adverse health effects of biannual time changes and support the elimination of biannual time changing and (2) recognize the positive health effects of daylight savings time and support daylight savings time as the permanent standard time.
(MSS CSI Report B, A-21)

440.110MSS Improving the Labeling of Over-the-Counter Medications by Including Carbohydrate Content: AMA-MSS supports the inclusion of carbohydrate content, in grams or micrograms, on labels for over-the-counter drugs. (MSS CSI Report C, A-21)

440.111MSS Increasing Access to TBI Resources in Primary Care Settings: AMA-MSS will ask the AMA to: (1) recognize disparities in the care for traumatic brain injuries, and acknowledge non-athletic traumatic brain injuries as a significant cause of morbidity and mortality, particularly for ethnic minorities and victims of domestic violence and (2) support increased access to traumatic brain injury resources in primary care settings which advocate for early intervention, encourage follow-up retention of patients for post-injury rehabilitation, and improved patient quality of life.
(MSS Res. 18, I-21) (AMA Res. 524, Adopted as Amended [], A-22)

440.112MSS Longitudinal Capacity Building to Address Climate Action and Justice: AMA-MSS will ask the AMA to: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (2) Aggressively advocate for prompt passage of legislation and policies that limit global warming to no more than 1.5 degrees Celsius over pre-industrial levels and address the health and social impacts of climate change through rapid reduction in greenhouse gas emissions aimed at carbon...
neutrality by 2050, rapid implementation and incentivization of clean energy solutions, and significant investments in climate resilience through a climate justice lens; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; and (4) Consider the establishment of a longitudinal task force or organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a net-zero carbon society by 2050, with report back to the House of Delegates. (MSS Res. 27, I-21) (AMA Res. 430, Adopted Alternate Resolution in Lieu of [], A-22)

440.113MSS Support Removal of BMI as a Standard Measure in Medicine: AMA-MSS will ask the AMA to: (1) recognize the significant limitations and potential harms associated with the widespread use of body mass index (BMI) in clinical settings and supports its use only in a limited screening capacity when used in conjunction with other more valid measures of health and wellness; and (2) support the use of validated, easily obtained alternatives to BMI (such as relative fat mass, body adiposity index, and the body volume index) for estimating risk of weight-related disease. AMA-MSS will ask the AMA to amend Policy H-440.866 by addition and deletion as follows:

H-440.866 – THE CLINICAL UTILITY OF MEASURING BODY MASS INDEX WEIGHT, ADIPOSITY, AND WAIST CIRCUMFERENCE IN THE DIAGNOSIS AND MANAGEMENT OF ADULT OVERWEIGHT AND OBESITY Our AMA supports:
(1) greater emphasis in physician educational programs on the risk differences among ethnic and age within and between demographic groups at varying weights and levels of adiposity BMI and the importance of monitoring waist circumference in all individuals with BMIs below 35 kg/m²;
(2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and
(3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.
(4) the understanding that weight does not inherently predict health and the recognition that physicians should evaluate the social and economic determinants of health and take into consideration the patient’s lived environment to help patients achieve meaningful and sustainable health goals regardless of their intentions to alter their weight. (MSS Res. 56, I-21) (AMA Res. 435, Referred, A-22)

440.114MSS Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families: AMA-MSS will ask (1) that our AMA recognize child poverty as a public health issue and a crucial social determinant of health across the life course, (2) that our AMA recognize that the disproportionate concentration of child poverty and generational wealth gaps experienced by Black, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity, and (3) that our AMA advocate for fully refundable expanded child tax credit payments and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for low-income U.S. residents. (MSS Res. 006, A-22) (Immediately forwarded to the HOD, AMA Res.
Assessing the Humanitarian Impact of Sanctions: AMA-MSS will ask (1) that our AMA recognizes that economic sanctions can negatively impact health and exacerbate humanitarian crises and (2) that our AMA supports legislative and regulatory efforts to study the humanitarian impact of economic sanctions imposed by the United States. (MSS Res. 017, A-22)

Recognizing the Burden of Rare Disease: AMA-MSS will ask (1) that our AMA recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases and (2) that our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases. (MSS Res. 027, A-22)

Increasing the Availability of Automated External Defibrillators: AMA-MSS will ask that our AMA amend Policy H-130.938, “Cardiopulmonary Resuscitation (CPR) and Defibrillators,” by addition to read as follows:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
(13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist.

(MSS Res. 029, A-22)
440.118MSS | SNAP Expansion for DACA Recipients: AMA-MSS will ask that our AMA actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify. (MSS Res. 030, A-22)

440.119MSS | Further Action to Respond to the Gun Violence Public Health Crisis: AMA-MSS will ask that our AMA convene a task force for the purposes of working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence; and reporting annually to the House of Delegates on the AMA’s efforts to reduce gun violence. (MSS Late Res. 001, A-22) (Immediately forwarded to HOD, AMA Res. 246, Refer for Report Back at I-22, A-22)

440.120MSS | Reducing Burden of Incarceration on Public Health: AMA-MSS will ask that our AMA (1) support efforts to reduce the negative health impacts of incarceration, such as (a) implementation and incentivization of adequate funding and resources towards indigent defense systems; (b) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; (c) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings; and (2) partner with the American Public Health Association and other stakeholders to urge Congress, the Department of Justice, and the Department of Health & Human Services to minimize the negative health effects of incarceration by supporting programs that facilitate employment and housing opportunities for formerly incarcerated individuals as well as research into alternatives to incarceration.

(MSS COLA CGPH Rep A, A-22)

445.000MSS | Public Relations

445.001MSS | Public Image of Physicians: (1) AMA-MSS: (a) will help develop community service and public education programs that serve to inform the public of health care issues and improve the public image of the AMA and the medical profession; and (b) will investigate possible advantages of involving medical students in AMA efforts to improve the public image of physicians and to assure the public that the primary role of physicians today continues to be that of advocates for their patient's health. (MSS Sub Res 25, I-85) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Modified: MSS GC Rep A, I-16) (Reaffirmed: MSS GC Rep A, I-21)


450.000MSS | Quality of Care

Eliminating Medical Tubing Misconnections: AMA-MSS supports the manufacture and use of medical tubing with designed incompatibility such that it is physically impossible to connect tubing intended for different health functions. (MSS Res 41, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

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**460.000MSS  Research**

**460.001MSS**  
**Pure and Applied Research:** AMA-MSS supports the following principles: (1) A commitment to stabilization of support for biomedical research and research training should be made by the government. (2) Private funding of academic research should be encouraged through a system of financial incentives. (3) The public's interest in a product of biotechnology, which it has substantially funded, should be protected even if commercial interests have funded the latter stages of the product's development. (4) In any system of regulation or incentive regarding private sponsorship of academic research, provisions should be made to actively encourage the role of training researchers as well as the role of conducting research. (5) Individuals and institutions must police themselves in order to combat overly restrictive regulation. (6) Greater decentralization of the decision-making authority from federal agencies to grantee institutions should occur, especially in the day-to-day management of grants and contracts. (7) Medical school admissions committees should develop criteria that do not penalize applicants who express interest in pursuing careers in biomedical research. (8) Federal support for training physician-scientists should be strengthened. (9) Medical schools should make available adequate elective laboratory research experience in the basic science years for those students interested. (MSS Rep C, I-82, Attachment 6) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
460.002MSS Biomedical Research & Research Training: AMA-MSS will apply its existing policy of support for biomedical research and research training by (1) continuing its support of the established peer review system whereby research funds are granted and (2) opposing any attempts to increase direct congressional control over the specific allocation. (MSS Sub Res 10, A-84) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

460.004MSS Human Genome Project: AMA-MSS will ask the AMA to: (1) endorse the scientific and medical objectives of the Human Genome Project; and (2) ask appropriate medical and scientific organizations to: (a) encourage worldwide support including monetary support, of advances in human genome research; (b) promote the free and open exchange of sequence information among nations; and (c) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind. (AMA Res 279, A-90 Adopted [H-460.962]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

460.005MSS Scientific Implications of Somatic Cell Nuclear Transfer Technology: AMA-MSS will ask the AMA to: (1) recommend a cessation of human somatic cell nuclear transfer research by both public and private sectors that involves the production of human beings; (2) work closely with the federal research funding agencies (NIH, NSF, NCI) and the Food and Drug Administration to determine if longitudinal animal studies indicate that nuclear transfer technology is safe and reproducible; and (3) encourage the applications of nuclear transfer technology for uses other than human reproduction by supporting basic science research programs that pursue medically therapeutic procedures such as organ or tissue transplantation. (MSS Sub Res 11, A-98) (AMA Res 11, A-98 Adopted [H-460.915]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

460.007MSS AMA Support for Manned Space Exploration of the Moon, and Mars that will Promote Medical Research and Enhance Patient Care: AMA-MSS will ask the AMA to publicly support a commitment for manned space exploration of the moon, Mars, and other celestial bodies for the benefits to medicine and advances in patient care. (MSS Res 7, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

460.008MSS Support for Increased Regulation in Tissue Procurement: AMA-MSS will ask the AMA to (1) support efforts by the FDA, the American Association of Tissue Banks, CDC, and other appropriate establishments to institute a uniform system of tissue tracking and a national database of tissue registry for tissues intended for nonclinical scientific and educational purposes; and (2) reaffirm AMA Policy H-370.988 – Regulation of Tissue Banking. (AMA Policy Reaffirmed in Lieu of AMA Res 702, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Comparative Effectiveness Research: It is policy of the AMA-MSS to support the creation of an independent organization that: (1) Conducts and supports research into the comparative effectiveness and cost effectiveness of new and existing medical interventions to increase information available for clinical decision-making; (2) publicly disseminates findings to medical professionals and patients; (3) involves representatives of physicians and patients in its governance; (4) ensures that all studies maintain the highest standards of scientific credibility and investigator integrity, including submission of studies through a peer-review process and rules regarding conflicts of interest; (5) receives funding from a dedicated funding source or sources not subject to Congressional appropriations; (6) recognizes that patients are unique individuals and while attempting to provide evidence for specific subgroups and circumstances, acknowledges that population-level research is not applicable to every clinical case; (7) does not make recommendations for public or private insurance coverage decisions or payment policies; and (8) does not issue physician practice guidelines. (MSS Amended Res 18, I-08) (Reaffirmed: MSS GC Report B, I-13) (Reaffirmed: MSS GC Rep A, I-19)


Medical Ghostwriting: AMA-MSS will ask the AMA to educate, at appropriate intervals, physicians and physicians-in-training about the currently-defined differences between being an “author” and being a “contributor” as well as the varied potential for industry bias between these terms and the importance of self-identifying between these terms when submitting manuscripts for publication in accordance with the following text:

(1) Authorship credit should be based on (a) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (b) drafting the article or revising it critically for important intellectual content; and (c) final approval of the version to be published. Authors should meet all three conditions. Those meeting fewer than all three criteria should be considered contributors. (2) When a large, multicenter group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship/contributorship defined above and should complete journal-specific author and conflict-of-interest disclosure forms. When submitting a manuscript authored by a group, the corresponding author should clearly indicate the preferred citation and identify all individual authors as well as the group name. Journals generally list other members of the group in the Acknowledgments. The National Library of Medicine indexes the group name and the names of individuals the group has identified as being directly responsible for the manuscript; it also lists the names of collaborators if they are listed in Acknowledgments. (3) Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship but rather, contributorship. (4) All persons designated as authors should qualify for authorship, and all those who qualify should be listed. (5) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. (MSS Res 48, I-10) (AMA Res 311, A-11 Adopted with Change in Title [H-460.972]) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
460.014MSS  Creation of National Registry for Healthy Subjects in Phase I Clinical Trials: AMA-MSS will ask the AMA to encourage the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in phase I trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and document previous trial participation. (MSS Sub Res 35, A-11) (AMA Res 913, I-11 Adopted [D-460.972]) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

460.015MSS  Understanding Medical School Support for Student Participation in Year-Out Research Programs: AMA-MSS will work with the AMA Academic Physicians Section, the AMA Council on Medical Education, and other appropriate groups to encourage medical schools to facilitate student participation in year-out research programs. (GC Rep D, A-11) (Modified and Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

460.016MSS  The Next Transformative Project: In Support of the BRAIN Initiative: AMA-MSS will ask the AMA to (1) support the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourage appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative; and (3) evaluate the role of our organization in ensuring the proper execution of the BRAIN initiative. (MSS Res 17, A-13) (Amended AMA Res 522, A-13 Adopted [H-460.904]) (Reaffirmed: MSS GC Rep A, I-19)

460.017MSS  Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials: AMA-MSS will ask the AMA to (1) support the timely dissemination of clinical trial data for public accessibility; (2) sign the petition titled “All Trials Registered; All Results Reported” at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; (3) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and (4) encourage the expansion of clinical trial registrants to clinicaltrials.gov. (MSS Res 23, A-15) (First, third, and fourth Resolves of Res 907, I-15 Adopted as Amended, H-460.912 and D-460.970 Reaffirmed) (Reaffirmed: MSS GC Rep B, A-21)

460.020MSS  Reintroduction of Mitochondrial Donation in the United States: AMA-MSS will ask the AMA to support regulated research to determine the efficacy and safety of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases to at-risk males. (MSS Res 70-I-17) (Adopted, HOD Res. 508, A-18 [H-480.942])

460.021MSS  Researching Drug Facilitated Sexual Assault Testing: AMA-MSS will ask the AMA to study the feasibility and implications of offering drug testing at point of care for date rape drugs, including but not limited to rohypnol, ketamine, and gamma-hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault. (MSS Res 69-I-17) (HOD Res. 505, A-18, Not Adopt)
Support for Preregistration in Biomedical Research: AMA-MSS will ask the AMA to support pre-registration of research studies to mitigate publication bias and improve the reproducibility of biomedical research. (MSS Res 07, A-18) (AMA Res 901, I-18, Adopted [H-460.941])

Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use: AMA-MSS will ask the AMA to encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use. (MSS Res. 17, I-19)

Patient Education and Security Risks Involving Direct-to-Consumer Genetic Testing: AMA-MSS will ask the AMA to:

(1) Address Direct-to-Consumer genetic testing by amending H-460.908, Genomic-Based Personalized Medicine, as follows:

H-460.908 – Genomic-Based Personalized Medicine
Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaboration and additional funding sources for such projects; (3) will continue to represent physicians’ voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information; and (4) will support efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts.
(2) Amend D-480.987, Direct-To-Consumer Marketing and Availability of Genetic Testing by insertion and deletion as follows:

D-480.987 – Direct-To-Consumer Marketing and Availability of Genetic Testing […]
(5) will work to educate and inform physicians and patients regarding the types, benefits and risks of genetic tests that are available directly to consumers, including, but not limited to information about the lack of scientific validity associated with some direct-to-consumer tests, privacy violations, and company ownership of patient data; so that patients can be appropriately counseled on the potential harms.

(3) AMA-MSS will amend 200.019MSS, Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems by insertion as follows:

200.019MSS – Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems
[...] (2) That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts; (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction.

(4) AMA-MSS will ask our AMA to support legislation regarding comprehensive security protection regarding direct-to-consumer genetic testing results to ensure patient privacy.

(MSS Res. 57, I-19)

460.025MSS Call for Increased Funding and Research for Post Viral Syndromes: Our AMA-MSS will ask the AMA to: (1) advocate for legislation to provide funding for research, prevention, control and treatment of post viral syndromes and long-term sequelae associated with COVID-19, including but not limited Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); (2) provide physicians and medical students with accurate and current information on post- viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS); and (3) collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face.
(MSS Res. 009, Nov. 2020)

460.026MSS Amending Policy H-525.988, “Sex and Gender Differences in Medical Research”: AMA-MSS will ask that our AMA amend Policy H-525.988, “Sex and Gender Differences in Medical Research,” by insertion as follows:

Sex and Gender Differences in Medical Research, H-525.988

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large; (2) affirms the need to include both all genders in studies that involve the health of society at large and publicize its policies; (3) supports increased funding into areas of women's health and sexual and gender minority health research; (4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities
in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative.
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities
(7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities.
(MSS Res. 016, A-22)

460.100MSS  Research: Animals

460.105MSS  Use of Animals in Research and Education: (1) AMA-MSS encourages medical school faculty who use non-human animals in the training of students to instruct students about the appropriate use of animals as experimental
subjects and encourages students and faculty to play an active role at their schools in developing institutional policies governing use of animals in laboratories and other classes at their schools; and (2) AMA-MSS will make a substantial effort to educate medical students about the necessity of well-designed and humane use of animals in research and education. (AMA Amended Res 93, I-83 Adopted [H-460.989]) (MSS Sub Res 4, A-88) (MSS Rep F, A-88) (Consolidated MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

465.000MSS  Rural Health

465.001MSS  Rural Health Opportunities for Medical Students: AMA-MSS will ask the AMA to encourage medical schools to develop Divisions of Rural Health within their Departments of Family Practice and encourage rural physicians to help increase rural health opportunities for medical students by participating as members of the medical school academic environment. (AMA Amended Res 308, I-94 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

465.002MSS  Medical Drone Use in Rural America: AMA-MSS promotes research on the use of medical drones in rural areas to deliver poorly stocked medical supplies, medical interventions and equipment. (MSS Res 02, I-18)

465.003MSS  Utilization of Telesurgery in Rural America: AMA-MSS supports research on telesurgery to help rural Americans with access to the best existing surgical interventions. (MSS Res 75, I-19)

470.000MSS  Sports and Physical Fitness


470.002MSS  Weight Loss in Interscholastic Wrestlers: AMA-MSS will ask the AMA to actively endorse efforts by state level high school athletic associations to establish programs that include enforceable guidelines concerning weight and body fat changes on a pre-competition basis for those sports in which weight management is a concern. (AMA Res 401, I-95 Adopted [H-470.994]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
470.003MSS Pre-Participation Screening in Student Athletes: AMA-MSS will ask the AMA to: (1) support the inclusion of the American Heart Association screening guidelines in the standardized pre-participation athletic examination for student athletes; and (2) recommend the use of further diagnostic modalities for those student athletes identified to be at risk by the American Heart Association screening guidelines, history, or physical examination. (MSS Amended Res 8, A-98) (AMA Res 409, I-98 Referred) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)


470.005MSS Combating Childhood Obesity with Physical Education Requirements: AMA-MSS will ask the AMA to advocate that schools require a health care professional’s recommendation for students to opt out of physical education programs, in order to stress the importance of physical wellness among children and to promote healthy lifestyle choices that extend into adulthood. (MSS Res 39, I-10) (AMA Res 412 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

470.006MSS Bicycle Sharing Programs: AMA-MSS (1) supports city governments in their investigation of the feasibility and economic sustainability of bicycle sharing programs; and (2) supports implementation of a bicycle sharing program in cities where the feasibility, economic viability, and potential health impacts are favorable. (MSS Res 30, A-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

470.007MSS Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention: AMA-MSS will ask the AMA to (1) support collegiate and professional athletic organizations adopting evidence-based guidelines for the evaluation and management of concussions; and (2) encourage further research into the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (MSS Res 20, A-13) (AMA Res 905, I-13 Adopted [H-470.957]) (Reaffirmed: MSS GC Rep A, I-19)

470.008MSS Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football: AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from long-term consequences of traumatic brain injuries and concussions in the sport of football at all levels. (MSS Res 46, A-15) (Reaffirmed: MSS GC Rep B, A-21)

470.009MSS Supporting a Minimum Age Limit for Tackle Football: AMA-MSS will support the establishment of a minimum age limit in tackle football participants. (MSS Res 21, A-19)
**480.000MSS Technology**

**480.001MSS Medical Technology Assessment:** AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic, ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trials when ethical prior to the wide spread dissemination of medical technologies and emphasize the importance of clinical trials to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for the assessment of medical technology. (MSS Position Paper 1, I-83) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

**480.004MSS Ultrasound Imaging:** AMA-MSS (a) affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians; (b) acknowledges that broad and diverse use and application of ultrasound imaging technologies exists in medical practice; (c) affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staff and should be specifically delineated on the Department’s Delineation of Privileges form; and (d) believes that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and ensure that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty society. (MSS Emergency Resolution 1, I-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

**480.007MSS Novel Technologies in Biometrics and Medical ID Bracelets Used to Enhance Security and Quality of Care:** AMA-MSS will ask the AMA to amend H-130.987 by insertion and deletion as follows:

H-130.987 Emergency Medical Identification Aids

The AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a
readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; and (4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card; and (5) encourages health insurance providers to offer enrollment in a virtual medical ID bracelet identification alert system as an optional health service, which can offer emergency responders immediate access to pertinent health information and family contact information.


480.010MSS Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship: AMA-MSS (1) supports our AMA urging the US Department of Health and Human Services (DHHS) to review tele-health initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and (2) supports our AMA seeking regulatory guidance from the DHHS regarding the essential requirements of web-based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services. (Sub Res 13, A-12) (Reaffirmed: MSS GC Report A, I-17)

480.011MSS Use of Integrated Pre-hospital Electronic Patient Care Reports for Pre-hospital Healthcare Providers: AMA-MSS will ask the AMA to support legislation incentivizing the comprehensive use of integrated electronic patient care reports by EMTs and paramedics for better cross communication, and to standardize the flow of information from pre-hospital to hospital. (MSS Res 14, A-12) (Reaffirmed: MSS GC Report A, I-17)

480.012MSS Preserving the Role of Physicians and Patients in the Evolution of Health Information Technology: AMA-MSS supports increasing the number of funded positions at all levels of graduate, medical, and allied health professional training in medical informatics to a level commensurate with current Health Information Technology (HIT) spending through mechanisms including, but not limited to, student research positions funded by National Institutes of Health (NIH) T and F programs. (MSS Res 14, I-12) (Reaffirmed: MSS GC Report A, I-17)
480.013MSS  The Role of Medical Students in the Development of Health Information Technology: AMA-MSS will work with our AMA and other relevant organizations to (a) facilitate active and timely medical student input on Health Information Technology research and development; and (b) continually determine how best our AMA-MSS can assist in the improvement of Health Information Technology. (MSS Res 31, I-13) (Reaffirmed: MSS GC Rep A, I-19)

480.014MSS  Support of Interstate Medical Licensure Compacts: AMA-MSS supports the development and adoption by states of interstate medical licensure compacts or uniform acts to enhance medical license portability. (MSS Sub Res 15, I-14) (Reaffirmed: MSS GC Rep A, I-19)


480.016MSS  Implementation of Cost-Effective Technologies as a Solution to Wandering Patients with Alzheimer’s Disease and Other Related Disorders: AMA-MSS will ask that our AMA support the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer’s disease and other related dementias with the help of appropriate allied specialty organizations. (MSS Res 16, I-15) (AMA Res 503, A-16 Adopted) (Reaffirmed: MSS GC Rep B, A-21)

480.017MSS  Secure Text Messaging Between Healthcare Providers: AMA-MSS supports usage of mobile devices messaging within clinical settings that is in compliance with the HIPAA Security Rule and minimally burdensome to healthcare providers. (MSS Res 18, I-16) (Reaffirmed: MSS GC Report A, I-21)

480.018MSS  Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research: AMA-MSS will ask that our AMA study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research. (MSS Res 15, I-16) (AMA Res 509, A-17 Existing Policy H-480.943 Reaffirmed in lieu of Res 509) (Reaffirmed: MSS GC Report A, I-21)

480.019MSS  Best Practices for Mobile Medical Applications: That our AMA develop and publicly disseminate a list of best practices guiding the development of mobile medical applications. (MSS Res 10, I-14) (Reaffirmed: MSS GC Rep A, I-19)

480.020MSS  Healthcare Applications for Blockchain Technology: AMA-MSS will study potential risks and benefits that blockchain technology may have on the healthcare industry, including but not limited to health care costs, security, interoperability, and claims adjudication. (MSS Res 25, I-17)

480.021MSS  Machine Intelligence and Data Science Literacy: (1) AMA-MSS supports the development of core physician data science competency guidelines; and (2)
AMA-MSS encourages medical schools to explore the implementation of more robust data science education. (MSS Res 36, A-18)

480.022MSS Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications: AMA-MSS will ask our AMA to amend policy D-480.972 to read as follows:

Guidelines for Mobile Medical Applications and Devices D-480.972

(1) Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.

(2) Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.

(3) Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.

(4) Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.

(5) Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.

(6) Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.

(7) Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.

(8) Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations.

(MSS Res 10, A-19) (AMA Res. 903, Adopt as Amended [D-480.972], I-19)

480.023MSS Net Neutrality and Public Health: AMA-MSS will ask the AMA to 1) advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network; 2) collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds; and 3) oppose internet data transmission practices that reduce market competition in the health ecosystem. (MSS CHIT Rep A, A-19) (AMA Res. 208, Combined with AMA Res. 211 and Referred for Study, I-19)
Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized: AMA-MSS will ask the AMA to (1) work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare; and (2) continue to monitor the evolution of blockchain technologies in healthcare and engage in discussions with appropriate stakeholders regarding blockchain development. (MSS CHIT/CEQM Rep A, I-18) (AMA Res 237, A-19, Adopted as Amended [D-478.962])

Ethics and Security of Brain-Computer Interfaces: AMA-MSS (1) supports research efforts investigating brain-computer interfaces, with emphasis on the safety and security of these devices and (2) supports legislation that makes it illegal to collect information from or send information to a brain-computer interface without informed consent. (MSS Res. 43, I-19)

Supporting HIPAA Coverage of Patients Mobile Health Data: Our AMA-MSS supports HIPAA or HIPAA-like requirements for all mobile health applications and wearable health technology such that data collected by these applications and devices is afforded the same privacy protections as standard medical records. (MSS Res. 039, Nov. 2020)

Encouraging Collaboration between Physicians and Industry in AI Development: Our AMA-MSS will ask the AMA to augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physicians members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on: (a) expanding recruitment among AMA physician members; (b) advising AMA physician members who are interested in healthcare innovation/AI without knowledge or proper channels to pursue their ideas; (c) increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies; (d) facilitating communication between companies and physicians with similar interests; (e) matching physicians to projects early in their design and testing stages; (f) decreasing the time and workload spent by individual physicians on finding projects themselves; and (g) above all, boosting physician-centered innovation in the field of AI research and development.

Our AMA-MSS will ask the AMA to support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (MSS Res. 121, Nov. 2020)

The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly: AMA-MSS will ask the AMA to: (1) support the development of a standardized definition of “age-friendliness” in health information technology (HIT) advancements; and (2) encourage the appropriate stakeholders to identify current best practices to set expectations of
HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults. (MSS Res. 28, I-21)

480.029MSS Evaluating Clinical Outcomes of Mobile Health Technology: AMA-MSS will ask the AMA to amend Policy D-480.972, “Guidelines for Mobile Medical Applications and Devices,” by addition as follows:

D-480.972 – GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES
1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will monitor and report on how mHealth apps and devices impact patient outcomes, especially in patient populations at whom interventions may be targeted, such as those managing chronic diseases and consumers seeking healthier lifestyles.
3. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful, and trustworthy mHealth market.
4. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
5. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
6. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
7. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
8. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
9. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.
(MSS Res. 31, I-21)

485.000MSS Television

485.001MSS Television Broadcast of Sexual Encounters and Public Health Awareness: AMA-MSS will ask the AMA to urge television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex. (AMA Amended Res 421, I-91 Adopted [H-485.994]) (Reaffirmed: MSS Rep B, I-00)

Machine Intelligence in Healthcare: AMA-MSS (1) supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision-making, including diagnosis, patient care, and health systems management; (3) supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) encourages the education of medical students and physicians on the use of machine intelligence in healthcare; (5) supports increased utilization of the term "machine intelligence" rather than the term "artificial intelligence" when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making. (MSS Res 37-I-17) (Reaffirmed: MSS Res 22, A-19)

Tobacco


"Smoke Free" Education: AMA-MSS will ask the AMA to: (1) encourage departments of education, through state and local medical societies, to expand health education programs targeted at 12 to 18 years old; (2) urge state societies to promote the use of the educational film "Death in the West", the educational program "Counseling Leadership About Smoking Pressure" (CLASP), and/or other programs that have demonstrated reductions in tobacco use by young people; and (3) work with the American Lung Association, American Heart Association, and the American Cancer Society to develop a list of physicians recommended as speakers for local television and radio stations to discuss the ill effects of tobacco usage and to advocate a smoke-free society by the year 2000. (AMA Sub Res 110, I-85 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Tobacco Cessation Counseling: AMA-MSS will ask the AMA to: (1) urge third party payors and governmental agencies involved in medical care to regard and treat tobacco use disorder counseling and/or treatment by physicians as an important and legitimate medical service; and (2) work with the US Public Health Service, particularly the Agency for Health Care Policy and Research, health insurers, and others to develop recommendations for third party payment for the treatment of tobacco use disorder. (AMA Amended Res 411, I-92 Adopted [H-490.916]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)


State Tobacco Tax Increases and Responsible Use of Resulting Funds: AMA-MSS will ask the AMA to support increases in the taxation of tobacco products with revenue from any such tax increases appropriated exclusively for the following uses: (1) educational, counter advertising and cessation programs designed to decrease the prevalence or the adverse effects of tobacco use, and (b) health related costs associated with tobacco use. (MSS Res 8, A-03) (AMA Res 803, I-03 Referred to BOT) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Use of State Tobacco Tax Revenue and Tobacco Settlement Fund Tracking and Publishing: AMA-MSS will ask the AMA to work with other interested organizations to seek and publish state by state accounting information regarding the specific uses of all state tobacco taxes and tobacco settlement funds. (MSS Res 9, A-03) (Reaffirmed Existing Policy in Lieu of AMA Res 804, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

490.021MSS Defining the Physical Boundaries and General Scope of Smoke-Free Policies on Medical Campuses and Other Institutions of Higher Education: AMA-MSS supports (1) the implementation of smoke-free policies on all medical campuses and institutions of higher education nationwide, wherein the geographic extent of the campus is defined as all buildings, facilities, grounds, and properties under the direct purview of the academic institution (in short, all properties owned by the institution, including all transportation vehicles), providing enforcement of such a policy does not interfere or conflict with state or federal law; (2) the enforcement of smoke-free policies at all institutions of higher education with the use of clearly displayed signs and placards, as well as the inclusion of information regarding the aforementioned policies in the institution’s policy statements and bylaws; and (3) a set of comprehensive guidelines on which other academic institutions should base their own smoke-free policies. (MSS Res 23, A-10) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

490.022MSS Federal Excise Tax for Tobacco Products: AMA-MSS will advocate for legislation establishing a federal excise tax on cigarettes such that the total cost of taxation of cigarettes will be indexed to the best available estimate of smoking-related health costs of a pack of cigarettes. (MSS Res 31, A-10) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

490.024MSS Banning Smoking While Driving in Vehicles in which Minors are Present: AMA-MSS will ask the AMA to support legislation that prohibits smoking while operating or riding in a vehicle that contains children. (MSS Res 25, A-13) (Reaffirmed: MSS GC Rep A, I-19)

490.025MSS Improved Regulations on Electronic Nicotine Delivery Systems (ENDS) and Electronic Cigarettes: AMA-MSS will (1) acknowledge the known harms of electronic nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices, and encourage physicians to recommend alternative therapies for smoking cessation; (2) work with federal agencies to discourage the promotion of electronic nicotine delivery systems both among adolescents and as smoking cessation devices; and (3) support increasing the age of purchase for all tobacco products from age 18 to 21. (MSS Res 28, A-18)

490.026MSS Decreasing Youth Access to E-Cigarettes: (1) Our AMA-MSS will ask the AMA to amend policy H-495.986 by addition as follows:

TOBACCO PRODUCT SALES AND DISTRIBUTION, H-495.986
Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children’s access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g. fines, prison terms, license revocation) to deter violation of laws restricting children’s access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchases; (d) measures to facilitate enforcement; (e) banning out-of-package cigarettes sales (“loosies”); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members;
(9) opposes the sale of tobacco at any facility where health services are provided;
(10) supports the sale of tobacco products be restricted to tobacco specialty stores;
(11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools; and
(12) supports measures that decrease the overall density of tobacco specialty stores.

(2) AMA-MSS supports evidence-based policies at federal, state, and local levels that prevent e-cigarette use among youth, including, but not limited to:
(a) Increased prices and/or taxes on e-cigarette products;
(b) Clean air laws that restrict e-cigarette use in public places, such as schools;
(c) Limitations on the number and location of e-cigarette retailers, and on where e-cigarette products are sold in stores;
(d) Bans on flavored e-cigarette products;
(e) Laws that reduce exposure to e-cigarette advertisements, such as on the internet and in TV and movies, magazines, and retail stores; and
(f) Media campaigns that educate youth on the adverse effects of e-cigarette use.


490.027MSS Providing Full Coverage for Smoking Cessation Treatments: AMA-MSS (1) supports working with state and local medical societies to formally request that state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state’s Tobacco Settlement Fund award annually to tobacco cessation programs; and (2) recommends that third-party payers and government agencies involved in medical care offer full coverage for smoking cessation products to smokers seeking counseling for quitting. (MSS Res 38, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

500.000MSS Tobacco: Marketing and Promotion

500.003MSS Tobacco Advertising Tax Deduction: AMA-MSS will ask the AMA to: (1) continue to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and (2) advocate that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion, and education. (AMA Amended Sub Res 204, A-93 Adopted [H-500.979]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

500.004MSS Picture-Based Warnings on Tobacco Products: AMA-MSS will ask the AMA to support appropriate legislation requiring picture-based warning labels on tobacco products produced in, sold in or exported from the United States.
500.006MSS  Restricting the Sale of E-Cigarettes to Minors: AMA-MSS supports (1) increased clinical research on the effects of electronic cigarettes; and (2) education on the effects of e-cigarettes to parents and their children in various settings ranging from schools to clinics. (MSS Res 1, A-14) (Reaffirmed: MSS GC Rep A, I-19)

505.000MSS  Tobacco: Prohibitions on Sale and Use


505.002MSS  Banning or Restricting Smoking in Public Places: AMA-MSS will ask the AMA to: (1) encourage and support efforts, legislative and otherwise, to ban or restrict smoking in all public places; (2) define "public places"; (3) ask that smoking be banned in public places where division into "smoking" and "no smoking" areas was not feasible; (4) ask that "no smoking" sections be large enough to accommodate the non-smokers who wish to utilize them; and (5) encourage that legislation in this area satisfy the four elements identified by the American Lung Association as important in assuring effective anti-smoking legislation. (AMA Res 86, I-79 Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


505.009MSS  Community Enforcement of Restrictions on Adolescent Tobacco Use: (1) AMA-MSS will support the development and distribution of educational materials designed to educate members and the public regarding FDA regulations on reporting sales of tobacco to minors. (2) AMA-MSS believes that these materials (which may include but are not limited to the current toll-free number) should be available at all sites of tobacco sales. (MSS Amended Sub Res 36, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)
Smoke-free Workplaces: AMA-MSS will ask the AMA to: (a) draft model legislation to eliminate smoking in public places and businesses; and (b) encourage individual medical students, residents, and physicians – as well as medical schools, hospitals, clinics, and physician practices – to endorse, support, and lobby for legislation to eliminate smoking in public places and businesses as a “workers right” issue. (MSS Res 1, I-02) (AMA Sub Res 923, I-02 Adopted [H-505.966]) (Amended: MSS Rep C, I-07) (Modified and Reaffirmed: MSS Rep C, I-12) (Modified and Reaffirmed: MSS GC Rep A, I-17)

Opposing the Sale of Tobacco in Retail and Grocery Stores: AMA-MSS will ask the AMA to support that the sale of tobacco products be restricted to tobacco specialty stores. (MSS Res 37, I-03) (AMA Res 413, A-04 Adopted [H-495.986]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

National Legislation Banning Smoking in Food Establishments: AMA-MSS will and will ask the AMA to actively pursue national legislation banning smoking in all cafeterias, restaurants, cafes, coffee shops, food courts or concessions, supermarkets or retail food outlets, bars, taverns, or in a place where food or drink is sold to the public and consumed on the premise. (MSS Amended Res 17, A-05) (AMA Amended Res 903, I-05 Adopted [D-490.979]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Amending H-490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing to Include E-Cigarettes: AMA-MSS will ask the AMA to amend policies H-490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes, to read as follows:

Smoke-free and Vape-free Environments and Workplaces H-490.913

On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke and vape exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry, and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the
public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy lifestyle for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to following the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, cigar, and e-cigarette smoking in any indoor area where children live or play, or where another person’s health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a non-smoking or a non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.
Tobacco Smoke and Vaping Exposure of Children in Multi-Unit Housing to Include E-Cigarettes H-490.907

Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing. (MSS Res 03, A-19) (AMA Res. 902, Adopt as Amended [H-490.913, H-490.907], I-19)

515.000MSS  Violence and Abuse

515.001MSS  Identifying Victims of Adult Domestic Violence: AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence (AMA Res 419, I-91 Adopted [D-515.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

515.002MSS  Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence: AMA-MSS will ask the AMA to: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats and stalking; and (2) support greater national and local protection for physicians and support personnel providing legal medical services. (AMA Sub Res 215, I-93 Adopted [H-460.945]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


515.004MSS  Gang Violence: AMA-MSS will ask the AMA to encourage the development of community-based programs that offer alternatives to gang membership. (AMA Amended Res 401, Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS

Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse: AMA-MSS will ask the AMA to work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected. (MSS Sub Res 1, I-08) (AMA Res 415, A-09 Adopted [D-515.982]) (Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS GC Rep A, I-19)

The Identification and Protection of Human Trafficking Victims: AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking. (MSS Res 19, A-12) (Reaffirmed: MSS GC Report A, I-17)

Addressing Sexual Assault on College Campuses: AMA-MSS will ask our AMA support universities’ implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting. (MSS Res 7, I-15) (AMA Res 402, A-16 Adopted [H-515.956]) (Reaffirmed: MSS GC Rep B, A-21)

Sexual Assault Survivors’ Rights: AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors’ rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate
with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. (MSS Res 21, A-17)

515.011MSS  
**Increased Use of Body-Worn Cameras by Law Enforcement Officers:** AMA-MSS will ask that our AMA advocate for legislative, administrative, or regulatory measures to expand funding for (i) the purchase of body-worn cameras and (ii) training and technical assistance required to implement body-worn camera programs. (MSS Res 43, A-17)

515.012MSS  
**Collecting and Releasing Data on Law Enforcement Use of Force:** AMA-MSS supports the collection of data by the CDC and state departments of health on serious law-enforcement-related injuries and deaths and supports making law-enforcement-related deaths a notifiable condition. (MSS Res 45, A-17)

515.013MSS  
**Trauma-Informed Care Resources:** AMA-MSS will ask the AMA to (1) recognize trauma-informed care, as defined by stakeholders as a practice that realizes the widespread impact of trauma on all patients, recognizes the signs and symptoms of trauma, responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeks to avoid re-traumatization, and understands potential paths for recovery; and (2) support trauma-informed care by directing physicians to evidence based resources. (MSS Res 21, I-18) (AMA Res 526, A-19 [H-515.952])

515.014MSS  
**Reducing the Prevalence of Sexual Assault by testing Sexual Assault Evidence Kits:** AMA-MSS will ask the AMA to amend policy H-80.999, Sexual Assault Survivors by insertion:

H-80.999 – Sexual Assault Survivors

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint
working group established for this purpose under the Survivor’s Bill of Rights Act of 2016.

4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all “backlogged” and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits.

(MSS Res. 28, I-19) (AMA Res. 210, Adopted as Amended [], A-22)

515.015MSS Amending H-515.952, Adverse Childhood Experiences and Trauma Informed Care, to Encourage ACE and TIC Training in Undergraduate Medical Education: AMA-MSS will ask the AMA to encourage a deeper understanding of Adverse Childhood Experiences and Trauma-Informed Care amongst future physicians, by amending H-515.952, Adverse Childhood Experiences and Trauma-Informed Care as follows:

H-515.952 – Adverse Childhood Experiences and Trauma-Informed Care
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 education 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.

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

(MSS Res. 64, I-19)

520.000MSS War


520.004MSS  **Nuclear, Biological, and Chemical Terrorism**: AMA-MSS will ask the AMA to: (1) work with the appropriate agencies (e.g. FEMA, DOD) to support ongoing efforts for medical preparedness in the case of a nuclear, biological or chemical (NBC) emergency, including but not limited to terrorist action; and (2) consider what training is necessary regarding nuclear, biological, and chemical agent education for civilian medical schools and residency training programs. (MSS Sub Res 28, I-98) (CSA Rep 4, A-99 Adopted in Lieu of Res 432, A-99 [H-130.949]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

520.005MSS  **Ensuring High Quality Care for All Veterans and Their Families**: Our AMA-MSS supports all avenues available to guarantee access to high quality health care for all eligible veterans and their families. (MSS Res 19, I-15) (Reaffirmed: MSS GC Rep B, A-21)

525.000MSS  **Women**

525.001MSS  **Inclusion of Women in Clinical Trials**: AMA-MSS encourages the inclusion of women, including pregnant women, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women. (AMA Res 183, I-90 Adopted [H-525.991]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Report F, I-10) (Reaffirmed: MSS GC Report A, I-16) (Modified: MSS Res 31, I-16) (Reaffirmed: MSS GC Report A, I-21)

525.002MSS  **Surgical Modification of Female Genitalia**: AMA-MSS will ask the AMA to: (1) encourage the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications, and possible corrective surgical procedures; and (2) oppose all forms of medically unnecessary surgical modification of female genitalia. (AMA Amended Res 13, A-91 Adopted [H-525.987]) (CSA Rep 5, I-94, Adopted [H-525.987]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Report F, I-10) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

525.004MSS  **Discrimination of Women Physicians in Hospital Locker Facilities**: AMA-MSS will ask the AMA to, request that the appropriate organizations require: (1) that male and female physicians have equitable locker facilities including
equal equipment, similar luxuries, and equal access to uniforms; and (2) that if physical changes must be made to the hospital's locker facilities to comply with these requirements, that they must be budgeted and implemented within a period of five years of the adoption of these requirements. (AMA Res 810, A-93 Adopted [H-525.981]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Report F, I-10) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

525.005MSS Cancer Screening and Sexually Transmitted Infection (STI) Risk in Women Who Have Sex Exclusively with Women: AMA-MSS will ask the AMA to (1) educate physicians regarding the need for women who have sex exclusively with women for regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (2) support its partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk. (MSS Sub Res 3, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

525.006MSS Supporting the Inclusion of Pregnant Women in Research: AMA-MSS (1) supports the update of federal, including FDA, regulations on human subject research with a proactive and inclusive approach to pregnant women in clinical research; and (2) supports the prioritization and advancement of research on medications’ effect on pregnancy and breastfeeding. (MSS Res 31, I-16) (Reaffirmed: MSS GC Report A, I-21)

525.007MSS Decreasing Sex and Gender Disparities in Health Outcomes: AMA-MSS will ask the AMA to (1) promote the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and (2) encourage the use of guidelines, and treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. (MSS Res 62-I-17)

525.008MSS Improved Accessibility of Feminine Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Woman: AMA-MSS will ask the AMA to (1) classify, and encourage the Internal Revenue Service to classify, feminine hygiene products as medical necessities; (2) support Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of feminine hygiene products; and (3) support consistent and ready access of feminine hygiene products across all publicly funded institutions, including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged women. (MSS Res 50-I-17)

525.009MSS Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products: AMA-MSS (1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products. (MSS Res 27-I-17)
Support for VA Health Services for Women Veterans: AMA-MSS recognizes the specific healthcare needs of the growing population of women veterans. (MSS Res 35-I-17)

Bridging the Gender Pay Gap: AMA-MSS (1) supports equitable compensation for all physicians with comparable experience performing equivalent work, and opposes gender-based discrimination in the workplace, and (2) supports efforts to address gender-based disparities in physician compensation including those that increase transparency during the hiring process, and internal reviews at the practice, department, or hospital system level that evaluate for gender-based discrimination pay gaps. (MSS Res 30 I-18)

Transparency Improving Informed Consent for Reproductive Health Services: AMA-MSS will ask the AMA to (1) work with relevant stakeholders to establish a list of Essential Reproductive Health Services, and (2) advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which Essential Reproductive Health Services are available at the organization along with any restrictions on Essential Reproductive Health Services at the institution, and include referral information to patients of other providers that cover the services within the same coverage area. (MSS Res 23, A-19) (AMA Res. 006, Withdrawn from Consideration, I-19)

Practice-Based Approach to Resolving Maternal Mortality and Morbidity in Racial Minorities: AMA-MSS supports development and implementation of evidence-based practices to prevent disease conditions that contribute to maternal morbidity and maternal mortality in racial and ethnic minorities. (MSS Res 42, I-18)

Banning the Practice of Virginity Testing: Our AMA-MSS will ask the AMA to: (1) advocate for the elimination of the practice of virginity testing exams, physical examinations purported to assess virginity; (2) support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support; and (3) support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients. (MSS Res. 025, Nov. 2020) (AMA Res. 009, Adopted [D-525.992])

Providing Widespread Access to Feminine Hygiene/Menstrual Products: (1) Our AMA-MSS will ask the AMA to encourage public and private institutions as well as places of work to provide free, readily available menstrual care products to workers and patrons. (2) Our AMA-MSS will ask the AMA to amend policy H-525.974, “Considering Feminine Hygiene Products as Medical Necessities,” as follows:

CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H- 525.974
Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the
removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs; and (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

(MSS Res. 106, Nov. 2020) (AMA Res. 209, I-21, Adopted [H-525.973])

525.016MSS  Inclusion of Hygiene Products in Supplemental Nutrition Programs: AMA-MSS will ask the AMA to: (1) support the inclusion of medically necessary hygiene products including, but not limited to menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs; (2) advocate for federal legislation that increases access to menstrual hygiene products, especially for recipients of public assistance; and (3) work with state medical societies to advocate for state legislation that increases access to menstrual hygiene products, especially for recipients of public assistance.

(MSS Res. 044, A-21) (AMA Res. 209, I-21, Adopt [H-525.973])

530.000MSS  AMA: Administration and Organization

530.003MSS  JAMA's Editorial Freedom: AMA-MSS (1) opposes the introduction of empowerment of a review board that would compromise JAMA's editorial freedom and independence; and (2) supports the concept that the editors of JAMA must have full authority for determining the editorial content of the journal.  (MSS Sub Res 57, A-90) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

530.004MSS  Conference Registration Fees: AMA-MSS will encourage the AMA to offer, whenever feasible, a discounted registration fee not to exceed $100 to AMA student members for all AMA sponsored conferences of interest to medical student members.  (MSS Sub Res 27, I-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


530.012MSS  Product Endorsements: AMA-MSS supports policy whereby the AMA shall not endorse any products or services produced by other companies and


530.017MSS Creation of a National Labor Organization for Physicians: AMA-MSS (1) supports the development and implementation by the AMA of a national bargaining unit under the National Labor Relations Act, consistent with our AMA Principles of Medical Ethics (Opinion 9.025), for employed physicians in professional practice, in order to retain the physician's role as the patient advocate, (2) vigorously supports national and state antitrust relief that permits collective bargaining between self-employed physicians and health plans/insurers/hospitals and others under the National Labor Relations Act, and (3) supports the development and implementation by the AMA of a national labor organization under the National Labor Relations Act consistent with our AMA Principles of Medical Ethics (Opinion 9.025) specifically for resident and fellow physicians. (MSS Amended Rep C, A-99) (Reaffirmed: MSS GC Report A, I-04) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


530.023MSS Equal Opportunity in Professional Affiliations for Physicians: AMA-MSS will ask the AMA to: (1) urge its state medical associations and constituent societies to oppose policy that directly or indirectly restricts or restrains any individual member’s freedom of choice with respect to professional societies for which they are eligible; (2) urge state medical associations to review and study membership provisions of their bylaws to maintain fair membership standards for equal access for all physicians and medical students; and (3) urge state medical associations to provide all medical students equal access to funding and opportunity within the realm of their society. (MSS Amended Res 10, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

530.024MSS Medical Student Participation in Professional Organizations: AMA-MSS will ask the AMA to work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization

530.025MSS Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations: Our AMA-MSS will ask that our AMA develop a plan with input from the LGBTQ+ advisory committee to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which will be given voluntarily by members and handled in a confidential manner. (MSS Res 06, A-16) (AMA Res 603, A-17 Adopted as Amended [updated G-635.125]) (Reaffirmed: MSS GC Report A, I-21)

530.026MSS Anti-Harassment Training: Our AMA-MSS will ask the AMA to: (1) require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continuous evaluation of the training for effectiveness in reducing harassment within the AMA; and (2) work with the Women Physicians Section, American Medical Women’s Association; GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer leadership. (MSS Res. 028, Nov. 2020) (AMA Res. 615, Adopted [], A-22)

530.027MSS Environmental Sustainability of AMA National Meetings: Our AMA-MSS will ask the AMA to: (1) commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA’s profens towards implementation; (2) work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials; (3) evaluate the feasibility of purchasing carbon offsets for member travel to and from Annual and Interim meetings and report back to the House of Delegates; and (4) evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design-certified or sustainable conference centers and report back to the House of Delegates. (MSS Res. 062/075, Nov. 2020)

535.000MSS AMA: Board of Trustees

Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations: AMA-MSS will ask the AMA to support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships, and other financial transactions by industry and commercial stakeholders. (MSS Res 16, I-18) (AMA Res 014, A-19, G-620.043)

AMA: Councils and Committees


AMA: House of Delegates

Medical Student Regional Delegate Apportionment: (1) AMA-MSS will ask the AMA to amend its bylaws such that Medical Student Regional Delegate (RD) and Medical Student Alternate Regional Delegate (AD) positions are allocated at a rate of one RD/AD for every 2,000 medical student members. These allocated RD/AD positions are then apportioned to the seven AMA-MSS Regions at a rate of one RD/AD per 2,000 medical student members within each region, with any remaining allocated RD/AD position(s) being apportioned to the Region(s) with the greatest number of medical student members in excess of a multiple of 2,000; and (2) AMA-MSS will amend its Internal Operating Procedures to reflect any amendments to the AMA Bylaws that affect the allocation or apportionment of Medical Student Regional Delegate and Medical Student Alternate Regional Delegate positions. (MSS GC Rep B, I-10) (AMA Res 605 Adopted, A-11 [D-615.980]) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Abolishment of the Resolution Committee: AMA-MSS will ask the AMA to abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion:

Resolution Committee, B-2.13.3

The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.

2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.
2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.

2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

(MSS Res. 012, A-21)

550.010MSS Updating AMA Bylaw 2.12.2, Special Meetings of the House of Delegates: AMA-MSS will ask our AMA to update its Special Meeting procedures by updating the Special Meetings Bylaws as follows:

1. Specification that the processes used to determine which items of business meet or do not meet the purpose for which the Special Meeting is called shall be published online and electronically sent to all members of the House of Delegates prior to the initiation of the Special Meeting.

2. Specification concerning the processes for how formal feedback may be submitted and reviewed prior to, during, and after the conclusion of the Special Meeting.

3. Description of how a Special Meeting report, detailing the processes that were used in the meeting, along with a summary of the concerns and suggestions submitted by the formal feedback mechanism, shall be produced by the Speakers and Board of Trustees following each Special Meeting that occurs.

4. Description of how, after each Special Meeting, a committee that is representative of House membership shall be formed for the purpose of (a) reviewing the Special Meeting and (b) proposing any improvements to the processes for future Special Meetings.

(MSS Resolution 01, I-21)

565.000MSS AMA: Political Action


565.002MSS Preserving the AMA’s Grassroots Legislative and Political Mission: AMA-MSS will ask the AMA to ensure that all Washington activities, including lobbying, political education, grassroots communications, and membership activities be staffed and funded so that all reasonable legislative missions and

565.003MSS Building AMA-MSS Membership through Promotion of AMPAC and State Medical PACs:
(1) AMA-MSS urges all regional delegates to annually recruit for AMPAC and state PAC membership among all medical students from their respective regions; (2) AMA-MSS will ask the AMA to urge all delegates to annually recruit for AMPAC and state PAC membership among all medical student members that they are in contact with; (3) Where state laws permit, AMA-MSS will encourage and will ask the AMA to encourage all medical students (regardless of AMA membership) to join state medical society PACs; (4) AMA-MSS will recognize and will ask the AMA to recognize the state and the medical student region with the highest percentage membership in AMPAC and/or state PACs at each annual meeting. (MSS Res 19, A-03) (AMA Res 616, A-03 Adopted [D-640.995]) (Reaffirmed: MSS Sub Res 36, A-04) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

565.004MSS Policy and Advocacy Opportunities for Medical Students: AMA-MSS will ask the AMA to: (1) establish medical student health policy and advocacy elective rotations for medical students based in Washington, DC.; and (2) support and encourage internal, state, and specialty organizations to offer health policy and advocacy opportunities for medical students. (MSS Res 18, I-14) (Reaffirmed: MSS GC Rep A, I-19)

565.005MSS Transforming for Tomorrow: Advocacy Framework: AMA-MSS will: (1) work to establish an additional legislative internship or clerkship opportunity for a medical student in the AMA’s Washington, D.C. Office; and (2) continue to explore potential partnerships with other branches of the AMA to enrich our student advocacy opportunities. (MSS GC Rep C, I-14) (Reaffirmed: MSS GC Rep B, A-21)

630.000MSS AMA-MSS: Administration and Organization

630.007MSS MSS Resolutions: It is the policy of the AMA-MSS that MSS resolutions, including the “whereas” and “resolve” clauses and footnotes, once submitted to the Medical Student Section may not, with the exception of retyping, be altered by staff or an MSS council or committee prior to the MSS Assembly Meeting without the consent of the author. (MSS Res 12, I-85) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A-21)

630.008MSS Referencing Data in Resolutions: It is the policy of the AMA-MSS that all data in resolutions which contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional
630.011MSS  Improved Access and Programming of Non-Scientific Issues in Medicine: AMA-MSS will: (1) explore better methods of disseminating information from the AMA-MSS to local chapters with the goals of increased access, and program development; and (2) develop a series of modular programs, which can be used by local chapters to educate their members on topics of importance to future physicians, according to the following guidelines: (a) the information must be flexible, dynamic, accessible and cost effective; (b) a variety of topics could be covered, including medical ethics, legal issues in medicine, the lifestyles of various specialties, medicine and the media, medical economics, etc. (MSS Res 14, I-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Rep A, I-21)


630.025MSS  Changes in MSS Resolutions Forwarded to the AMA House of Delegates: It is the policy of the AMA-MSS that the MSS Delegate and Alternate Delegate to the AMA House of Delegates (when they agree) may make grammatical or syntax changes in MSS resolutions before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the MSS resolutions be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to an MSS resolution before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolution. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution. (MSS Res 43, A-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed:
630.037MSS Reaffirmation Calendar: AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide “statements of support” for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy. (MSS Amended Res 17, A-93) (MSS Rep C, I-93) (MSS Amended Rep C, I-97) (Reaffirmed: MSS GC Report A, A-16) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)


630.044MSS Sunset Mechanism for AMA-MSS Policy: AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five-year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation; (4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council. (COLRP Rep B, I-95) (MSS Amended Rep C, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21) (MSS Amended GC Report A, A-22)
AMA Medical Student Section Vision Statement: The AMA-MSS supports the following vision statement for the AMA-MSS: (1) The AMA-MSS core purpose is: the AMA-MSS is dedicated to representing medical students, improving medical education, developing leadership and promoting activism for the health of America; (2) The AMA-MSS Envisioned Future is: The AMA-MSS strives to be the medical students’ leading voice for improving medical education, advancing health care and advocating for the future of medicine.; (3) The AMA-MSS Objectives are: (a) The leading medical student organization for advancing issues of public wellness, community service,
ethics, and health policy; (b) The principal source for obtaining and disseminating information for medical students regarding medical education, residency training, and medical practice; (3) The most representative voice and influential advocate for medical students and their patients; and (4) A dynamic organization that provides value to its medical student members; and (4) The AMA-MSS Core Values are: (a) Advocacy: Caring advocates for our patients, our profession, and our medical student members. (b) Leadership: The stewards of the future of medicine. (c) Excellence: Commitment to provide the highest quality service, products, and information for our members. (d) Integrity: Ethical behavior forms the basis for trust in all our relationships and actions. (MSS COLRP Rep B, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

630.050MSS Creating a Community Service Project: AMA-MSS will undertake a limited local service project as part of its agenda at its Annual and Interim Meetings, at a time determined by the Governing Council, as appropriate based on the schedule of activities. (MSS Sub Res 16, A-98) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

630.051MSS AMA-MSS Digest of Actions: It is the policy of the AMA-MSS that the AMA-MSS Internal Operating Procedures and Digest of Actions be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly. (MSS Sub Res 21, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

630.055MSS Implementation of MSS Policy: AMA-MSS will report at each meeting on the progress of all resolutions passed at the meeting five years previous to the current, especially focusing on action called for by external policies. (MSS Rep C, A-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

630.069MSS Developing our Regions: (1) AMA-MSS reaffirms the roles of the Regional Chairs; (2) AMA-MSS recognizes that the roles of the Region are to provide a home within the MSS, to serve as a communication unit for the MSS, to provide a means to foster collaboration between the chapters and states, and to facilitate interaction and integration of newly developing chapters with well-established chapters; (3) AMA-MSS recognizes the Regional Leadership for their time, efforts and selflessness. (MSS Regions Task Force Rep A, A-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

630.073MSS Voting Rights of MSS Speaker and Vice Speaker: Our AMA-MSS (1) will amend its Internal Operating Procedures IV.A by deletion as follows:

A. Designations. The officers of the MSS shall be the eight Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate AMA Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker. The Chair-elect/Immediate Past Chair shall be a non-voting member of the
Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker. The Speaker and Vice Speaker shall be non-voting members of the Governing Council; and

(2) amend its Internal Operating Procedures IV.E by addition and deletion as follows:

1. The Chair-elect/Chair/Immediate Past Chair of the Governing Council shall serve a two-year term. His or her term as Chair-elect will begin at the conclusion of the Interim Meeting at which he or she is elected. He or she will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. He or she will serve as Immediate Past Chair until the conclusion of the following Interim Meeting.

2. The other Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA House of Delegates.

3. Maximum tenure for members of the MSS Governing Council will be two years in any combination of voting or non-voting positions. The periods of service as Chair-elect and Immediate Past Chair shall not count toward the maximum tenure of two years in any combination of voting or non-voting positions.

(MSS GC Res 01, I-16) (Reaffirmed: MSS GC Report A, I-21)

630.074MSS Review of AMA-MSS Statements of Support of HOD Policies: (1) The formally-supported policies specified for action in Appendix 1 of this report be acted upon as recommended; and (2) the AMA-MSS Governing Council review the “AMA-MSS Statements of Support for HOD Policies” section of the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support. (MSS GC Report B, A-17)

630.075MSS Pilot Implementation of the 2018 Resolution Task Force Recommendations: MSS will:

1. Invest in further education efforts of the resolution process by: a) training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS; and b) Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made;

2. Elevate the stature of non-resolution avenues for advocacy by: a) clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals; b) creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair; c) Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee;
3. Encourage mentorship between its members and throughout the AMA by: a) Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process; and b) Requiring all external resolution authors to contact the relevant specialty society prior to submission;

4. Improve transparency of resolution feedback among all actors throughout the resolution process by: a) tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office; b) Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed; c) Requiring primary reviewers to send feedback summary emails to the primary author’s Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to; d) Requesting that HCC post a summary of their comments from the draft review process to the VRC; e) Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered;

5. Streamline existing procedures in the resolution process by: a) Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached; b) Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent calendar will not receive detailed staff review except analysis from Legal Counsel; c) Adjusting resolution deadlines to allow more time for review between the final submission and the VRC;

6. Change its scoring rubric to: a) Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale; b) For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives; c) Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category;

7. Reaffirm its existing process of creating the Assembly’s Order of Business according to quantitative resolution scores;

8. Create and further opportunities for high-quality discussion in the Assembly by: a) The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action Item. GC Action items may be submitted by the originating author or by individual members of the Section; and
9. Improve continuity of its advocacy efforts from meeting to meeting by: a) Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly; b) Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC and shared with the Section membership; and c) Giving the MSS GC responsibility for conducting an annual survey that sets MSS Policy Objectives for the given year.

(Amended GC Rep A, A-18)

640.000MSS  AMA-MSS: Committees


640.003MSS States Regional Chairs: AMA-MSS, through Regional Chairs will: (1) continue to encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist; (2) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections; (3) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and (4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs. (MSS Rep K, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified and Retained: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep A, I-21)

640.008MSS MSS Committee Reports: It is the policy of the AMA-MSS that the AMA-MSS Governing Council may suggest changes to committee reports but may not alter them without consultation with and agreement of the committee. Further, the Governing Council may include an addendum to the committee report, should a dissenting opinion exist, to distinguish the opinions of the Governing Council from those of the committee. (MSS Rep L, I-91, Adopted in lieu of MSS Res 44, A-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)
640.011MSS **Region Chair Elections:** AMA-MSS will modify its policy on the Region Chairs to allow for direct election of the Region Chairs by the sections, according to the following guideline: New chairs must be selected before Saturday morning of the annual meeting, and the new chair must be present at the annual meeting. (MSS Rep F, A-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Rep B, I-09) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

640.013MSS **AMA-MSS Standing Committees:** The AMA-MSS Governing Council will: (1) outline the creation, maintenance, and dissolution of standing and ad-hoc committees and report back at I-05; (2) handle requests for funding from MSS standing or ad-hoc committees on a case by case basis with the committee that is requesting the funding presenting a justifiable proposal, which clearly meets the Governing Council’s goals, 30 days in advance of the monetary need; and (3) seek funding for two conference calls per committee per year. (MSS Rep F, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

640.014MSS **Regional Representation on MSS Committees:** The AMA-MSS Governing Council will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by using regional diversity as one of the selection criteria for all MSS Committees. (MSS Amended Sub Res 21, I-07) (GC Rep C, A-10 Filed [640.016MSS]) (Modified and Reaffirmed: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

[Start at 640.017MSS]

645.000MSS **AMA-MSS: MSS Assembly**


645.012MSS **Health Policy Programming:** The AMA-MSS Governing Council will continue to identify ways to incorporate educational opportunities in health policy into the national meeting structure as appropriate. (MSS Rep D, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

645.013MSS **Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD:** AMA-MSS will conduct an open hearing on Saturday at each Annual and Interim meeting, to hear pertinent items of business that will be coming before the AMA-HOD at that meeting. (MSS Sub Res 4, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)
Non-Voter Participation During the Assembly Portion of the AMA-MSS Annual and Interim Meetings: (1) AMA-MSS will continue to sponsor a Community Service project during Business Meetings of Medical Student Section. (2) The AMA-MSS Governing Council will: (a) continue to investigate and implement alternative activities for non-voting participants including but not limited to residency fairs, workshops, and lectures; (b) establish a separate convention committee to organize and implement NSP activities during the meetings; and (c) investigate ways to further promote and expand the activities of the sectional meetings. (COLRP Rep B, A-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Modified: MSS GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)


Medical Student Section Policy Making Procedures: (1) As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue; (2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates; (3) The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD’s “Implementation of Resolutions and Report Recommendations” documents, and that these updates be archived as an historical record of GC actions; (4) AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar; (5) The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar; (6) AMA-MSS will continue to use and enforce the mandatory MSS Resolution Checklist; (7) When MSS policy comes up for sunsetting, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted. (MSS Rep A, A-08) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Advocating for the Continuation of a Fall Meeting of the Medical Student Section: Due to its critical and unique role in our Section, AMA-MSS will advocate for the continuation of a Fall Meeting of the AMA-MSS that is

645.031MSS  Policy-making Procedures: (1) A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions. (2) A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. (3) That Reference Committees be encouraged to recommend GC Action Items in future report reasoning. (4) All authored resolutions are submitted to the region of the resolution’s primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution’s author to offer feedback and suggestions prior to the MSS final resolution deadline (5) All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author’s school is not located, with each resolution’s average ranking subsequently being released to the author. (6) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines. (Amended GC Rep A, A-13) (Amended and Reaffirmed: MSS GC Rep A, I-19) (Amended: Res. 027, A-21)

645.032MSS  Continued Support for the Virtual Reference Committee: AMA-MSS supports the continued implementation and utilization of the Virtual Reference Committee, including the use of online testimony to develop a Reference Committee report prior to each AMA and AMA-MSS national meeting. (MSS Res 9, I-13) (Reaffirmed: MSS GC Rep A, I-19)

645.034MSS  Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates: AMA-MSS will study the outcomes of MSS resolutions in the AMA House of Delegates including both objective measures of resolution adoption rates as well as subjective measures of the degree to which MSS goals were met regardless of outcome. The AMA-MSS Governing Council, under the direction of the Delegate and Alternate Delegate, consider using the results of the study to continue to improve and update the resolution writing process and report back to the MSS Assembly at intervals deemed appropriate by the AMA-MSS Governing Council. (MSS Res 02, I-17)
650.000MSS AMA-MSS: MSS Assembly – Sections


655.000MSS AMA-MSS: Membership and Dues

655.001MSS Student Membership in State Medical Societies: AMA-MSS will ask the AMA to: (1) support and encourage student membership and participation in state medical societies; to encourage societies to establish student dues that do not exceed 50 percent of the national student dues; and (2) seek the removal of any impediments to student membership in the AMA or in state or county medical societies. (AMA Res 92, I-79, Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

655.002MSS Membership Recruitment Methods: AMA-MSS: (1) endorses the concept that mechanisms of offering medical students free membership in the AMA and/or constituent societies should require direct action by medical students to accept the offer; (2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members; (3) does not oppose partial subsidization of AMA student dues by constituent societies as a positive incentive for medical students to join the AMA; and (4) supports medical student representation in state delegations to the AMA House of Delegates, with the goal of having a proportional number of delegate seats based on student membership. (MSS Rep I, A-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

655.003MSS Dual State Society Membership for Medical Students: The AMA-MSS Governing Council will ask the Department of Membership to encourage state medical societies to allow medical students to hold membership in the state society in which they attend medical school and also an associates membership in their state of permanent residence and that associate memberships in a state society not be counted in determining the number of AMA delegates

655.004MSS Medical Student Membership Benefits: AMA-MSS will ask the AMA to: (1) acknowledge all new student applications within two weeks of receipt of applications and that this acknowledgment contain the name and a phone number, which may be dialed collect, of an AMA staff member responsible for benefit inquiries and grievances; (2) ensure the distribution of journals to new members within 8 weeks of receipt of applications; and (3) provide benefits, free of charge, to new members processed before January until official membership begins in January according to the AMA calendar. (AMA Res 127, A-86 Referred) (BOT Rep X, I-86 Filed) (BOT Rep GG, A-88 Filed) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

655.005MSS Recruitment Information in AMA and MSS Pamphlets: (1) It is the policy of the AMA-MSS that recruitment literature distributed to students by the AMA and/or MSS clarify that AMA membership does not automatically imply membership in state or county/local medical societies. (2) AMA-MSS recruitment literature will stress the benefits of membership on the national, state, and county/local levels. (MSS Res 15, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

655.015MSS Eligibility of Medical Students to Join the AMA while Enrolled in a Joint Degree Program: AMA-MSS will use peer-to-peer recruitment to identify and recruit, on an individual basis, joint degree students who begin their education in a discipline other than medicine. (MSS Rep D, I-95, Adopted in lieu of Res 46, A-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)


655.018MSS Membership Retention into Residency: AMA-MSS will continue to explore ways to increase awareness of the Medical Student and Resident Fellow Sections in order to increase membership retention during the transition to residency. (MSS COLRP Rep A, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)
655.022MSS  MD/PhD AMA Membership: AMA-MSS will develop a mechanism for MD/PhD students and other students requiring greater than a 4-year training period to sign up for a longer AMA-MSS membership and make this available on the world wide web. (MSS Amended Res 15, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

655.024MSS  Improving Federated Membership Recruitment and Portability: AMA-MSS supports the development of a system whereby medical student, resident/fellow, and young physician members of the AMA, state, and county medical societies may rapidly transfer their new or existing memberships to the appropriate state and county medical societies of their new program or practice. (MSS Sub Res 9, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

655.025MSS  Increasing the Efficiency of Student Membership Application Processing: AMA-MSS encourages the AMA to continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members. (MSS Sub Res 4, A-01) (Amended MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

655.028MSS  The Designation of Permanent Membership Positions Within Local AMA-MSS Chapters: AMA-MSS strongly encourages every medical school to designate a permanent position within their chapter to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the chapter provide the individual’s name and current mailing address to the AMA Medical Student Section Outreach Program prior to each Annual Meeting. (MSS Res 1, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

655.033MSS  Establishing a Joint MSS and RFS Approach for Recruitment Initiatives for Incoming MSS Members to the RFS: AMA-MSS will: (1) work with the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (2) work with medical school deans to find better means to recruit 4th year medical students to the AMA-RFS including increased presence at match day and graduation events. (MSS Amended Res 5, A-05 Adopted) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

655.034MSS  Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA:
1. The AMA-MSS Governing Council, in Collaboration with Region leadership and appropriate AMA staff members, will further explore barriers to medical student participation in the AMA, including, but not limited to, costs association with AMA conference attendance, funding sources of delegates and other conference attendees and needs not met by state medical societies.
2. AMA-MSS will ask the AMA to explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences.

660.000MSS AMA-MSS: Officers – Nomination, Election, and Tenure

660.001MSS Questions of Parliamentary Procedures: (1) The AMA-MSS parliamentarian will be either the Speaker or Vice Speaker, whoever is not presiding over the Assembly. (2) The AMA-MSS Governing Council will appoint a temporary parliamentarian when either the Speaker or Vice Speaker is not present. (MSS Sub Res 5, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

660.017MSS Campaign Reform: AMA-MSS encourages all members to recognize the commitments of the candidates at the Interim and Annual meetings and use prudent judgment when inviting them to address group meetings and furthermore strive for fair and equal access to all candidates and all sections, states, and societies. (MSS Amended Sub Res 3, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

660.026MSS Councilor Selections: It is the policy of the AMA-MSS that AMA-MSS Governing Council members shall excuse themselves from all formal and informal Governing Council discussion and selection of any position for which they are candidates. (MSS Amended Res 7, A-05 Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

660.036MSS Creating an AMA-MSS Election Task Force: Our AMA-MSS will create an Election Task Force, consisting of at least two region-appointed voting members from each region and non-voting MSS Governing Council members, to review election rules and processes pertaining to Governing Council elections and provide recommendations for the equitable application and enforcement, and report back to Assembly at A-21. (MSS Emergency Resolution 001, Nov. 2020)

Note: This policy has been determined to be in conflict with one or more elements of our MSS Internal Operating Procedures (IOP) and will be enacted to the extent possible within the constraints of the MSS IOP.

660.037MSS Expanding the AMA-MSS Governing Council to Include a Diversity, Equity, & Inclusion Officer:
(1) That our AMA-MSS expands its Governing Council to include an annually elected Diversity, Equity, and Inclusion Officer empowered to and charged with the sustainable prioritization of these values within our section;
(2) That our AMA-MSS amends its Internal Operating Procedures as follows:
4.1 Designations. The officers of the MSS shall be the eight nine Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate Delegate, At-Large Officer, Chair-Elect, Immediate Past Chair, Speaker, and Vice Speaker, and Diversity, Equity, and Inclusion Officer. The Chair-Elect/Immediate Past Chair shall be non-voting members of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

4.4.6 Diversity, Equity, & Inclusion Officer: The Diversity, Equity, & Inclusion Officer shall:

4.4.6.1 Coordinate the AMA-specific activities of the identity-based National Medical Student Organizations liaisons (as defined in MSS IOP 10.3.3), identity-based Professional Interest Medical Association liaisons (as defined in MSS IOP 10.3.2), and identity-based AMA-MSS Standing Committees within the Section.

4.4.6.2 Serve as a liaison between the AMA’s Center for Health Equity, the MSS, and the MSS Governing Council.

4.4.6.3 Serve as a liaison between identity-based National Medical Student Organization leadership and the Section.

4.4.6.4 Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), Women Physicians Section (WPS), the Advisory Committee on LGBTQ Issues, and other identity-based sections or groups within the AMA.

4.4.6.5 Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative AMA-MSS membership and leadership.

4.4.6.6 Develop and maintain a culture of inclusivity and allyship within the Section.

6.7.3 First Ballot. At the Interim Meeting, one ballot shall be used by the credentialed MSS Delegate to case cast one vote for the Chair-Elect and one vote for the Medical Student Trustee. At the Annual Meeting, individual ballots for each position shall be used by the credentialed MSS Delegate to case cast one for each of the four five positions: the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. No ballot should be counted if there is more than one vote for a position. All Governing Council positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.

6.8 Endorsements for Diversity, Equity, & Inclusion Officer. Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based Standing Committees, liaisons to identity-based National Medical Student Organizations (as defined in MSS IOP 10.3.3), liaisons to Professional Interest Medical Associations (as defined in MSS IOP 10.3.2) and liaisons to identity-based AMA Sections and Advisory Committees (as defined in AMA Bylaw 7.0.1).
6.8.1 Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.

6.8.2 Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.

6.5.7.3 No mode of MSS- or AMA-sponsored communication, including, but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning unless otherwise outlined in this IOP.

6.5.9.1 Only MSS members may be involved in a candidate’s campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role within or outside of the organization unless otherwise outlined in this IOP.

6.7.2 Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-Elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, AMA Delegate, At-Large Officer, and Speaker, and Diversity, Equity, & Inclusion Officer. An additional balloting period will be held for the elections of the Alternate Delegate and Vice Speaker.

(3) That our AMA-MSS Governing Council, with input from AMA-MSS identity-based Standing Committees and National Medical Student Organization liaisons, appoint an individual at the AMA-MSS 2021 Interim Business Meeting to serve as an interim Diversity, Equity, & Inclusion Officer, who will be fully empowered as a member of the Governing Council, but not allowed to vote until elected by the Section, until the AMA-MSS 2022 Annual Business Meeting election can occur.

(MSS Res 001, A-21)

665.000MSS AMA-MSS: Regional Operations

665.001MSS Strengthening of Regional Internal Operating Procedures (IOPs), Creation of Regional Coordinating Committees, and Creation of Membership/Recruitment Chair for Each Region: (1) It is the policy of the AMA-MSS that the following sections within each region’s Internal Operating Procedures be standardized: (a) Name, (b) Purpose and Principles, (c) Membership, (d) Method for Substituting Regional Delegates at the National Meetings, (e) Number of Required Meetings, (f) Quorum, (g) Parliamentary Authority, (h) Amendments, and (i) Supremacy and Severability, while leaving the content of the Elections, Voting, and Committees sections up to each region individually; (2) Region Chairs should work with emerging chapters and create a Membership/Recruitment Chair for their respective region, and (3) Region Chairs should undertake pilot projects to build region funding. (MSS RIT Force Rep A, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)
Evaluation of AMA-MSS Region Bylaws: It is the policy of the AMA-MSS:

1. That all Medical Student Region Bylaws include, at minimum, abbreviated versions of:

   a. The purpose of the Medical Student Region to elect Regional Delegates to the AMA House of Delegates per MSS IOP VIII. A;
   b. The responsibilities of the Region Chair per MSS IOP VIII. A.3;
   c. An outline of the requirements for Regional Delegate Elections per MSS IOP VIII. B.2;
   d. Descriptions of their Regional Governing Council per MSS IOP VIII. A.4; and
   e. Determination and Responsibilities of the Regional Delegate Chair per MSS IOP VIII. C.

2. That all Medical Student Region Bylaws are in accordance with the prevailing parliamentary code of our AMA per MSS IOP XII.A.

3. That the Speaker or Vice Speaker or their designee be authorized to correct article and section designations, punctuation and cross-references, and to make such other technical and conforming changes as may be necessary to reflect the intent of the MSS with respect to the Medical Student Region bylaws requirements as recommended by this report.


Evaluating the Value of Region Restructuring (Follow Up): (1) The existing AMA-MSS region structure will remain unchanged and (2) the AMA-MSS assess each region’s membership numbers and degree of engagement with the AMA-MSS at least every 5 years. (MSS GC Report B, I-16) (Reaffirmed: MSS GC Report A, I-21)

Reevaluation of AMA-MSS Region Bylaws: (1) That our MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15; and (2) That Region 6 modify their bylaws to specify the responsibilities of the Region Chair to be in accordance with MSS IOP 8.1.3; and (3) That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection of Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.3; and (4) That our MSS-COLRP reevaluate the accordance of each Region’s bylaws with the categories in Tables 1 – 5b and release its findings in an informational report to the Assembly at A-24. (MSS COLRP Report A, A-17) (Amended MSS COLRP Report A, A-22)

Amending G-630.140 Lodging, Meeting Venues and Social Functions: AMA-MSS will ask our AMA to amend policy G-630.140 Lodging, Meeting Venues, and Social Functions to read as follows:

Lodging, Meeting Venues, and Social Functions G-630.140

(1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost and similar factors.
(2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel, or in a hotel close in proximity.

(3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances to justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies and other health organizations to adopt a similar policy.

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

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

(MSS Res 17, A-19)

665.017MSS Re-evaluation of AMA-MSS Region Bylaws: It is the policy of the MSS:

1. That Region 1 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4;

2. That Region 2 modify their bylaws to specify the responsibilities of the Region Delegation Chair and Region Chair and specify the selection of the Regional Delegate to be in accordance with MSS IOP 8.4, MSS IOP 8.1.3 and MSS IOP 8.3 respectively;

3. That Region 3 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4;

4. That Region 4 modify their bylaws to include the process in which the Region Chair and, Region Delegates, and Region Delegation Chair are selected and the responsibilities of the Region Delegation Chair and Region Chair to be in accordance with MSS IOP 8.1.3, MSS IOP 8.5, and MSS IOP 8.4;

5. That Region 5 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4;

6. That Region 6 modify their bylaws to include details on the process in which the Region Delegation Chair and Region Delegate is selected and the responsibilities of the Region Delegation Chair and Region Chair, and eliminate the exclusion where the Region Delegation Chair cannot be an Alternate Delegate to be in accordance with MSS IOP 8.1.3, MSS IOP 8.3, and MSS IOP 8.4;
7. That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection and responsibilities on the Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.4; and
8. That our MSS-COLRP re-evaluate the accordance of each Region’s bylaws with the categories in tables 1-5b and release its findings in an informational report to the Assembly at A-21.

(MSS COLRP Rep A, A-19)
AMA-MSS Statements of Support for HOD Policies

Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid: The MSS formally establishes supports for the following AMA policy:

Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid H-305.941
AMA policy is to pursue changes to federal legislation or regulation, and specifically to the Higher Education Act, to change the cost of attendance definition for medical education to include costs for food, shelter, clothing and health care for all dependents, and for dependent care. (Res. 205, I-97; Reaffirmed: CME Rep. 2, A-07)

(MSS Res 9, A-97)

Physician Involvement in the Care for the Uninsured: The MSS formally establishes support for the following HOD policy:

H-160.961 Caring for the Poor
(1) Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients. In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity. Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as: by seeing indigent patients in their offices at no cost or at reduced cost, by serving at freestanding or hospital clinics that treat the poor, and by participating in government programs that deliver health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless. In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (2) State, local, and specialty medical societies should help physicians meet their obligations to provide care to the indigent. By working together through their professional organizations, physicians can provide more effective services and reach more patients. Many societies have developed innovative programs and clinics to coordinate care for the indigent by physicians. These efforts can serve as a model for other societies as they assist their members in responding to the needs of the poor.

(MSS Res 45, I-98)

Disparity in Mental Health Coverage: The MSS formally establishes support for the following HOD policies:

H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs
Our AMA supports parity of coverage for mental illness, alcoholism and substance use.

H-185.986 Nondiscrimination in Health Care Benefits
Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured. (Res. 58, A-91; Reaffirmation A-97; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10)

(MSS Res 62, I-98; Reaffirmed: MSS Rep C, A-04)

Skin Cancer Prevention in Children: The MSS formally establishes its support for the following HOD Policies:

H-170.969 Teaching Preventive Self-Examinations to High School Students
The AMA supports the development of comprehensive high school health curricula in conjunction with local medical societies and health departments. This curriculum should include instruction in appropriate self-examinations of the skin, breasts, testes and other systems.

(MSS Res 26, A-99)

Regulation of Tattoo Artists, Skin Piercers, Facilities: The MSS formally establishes support for the following AMA policies:

H-440.909 Regulation of Tattoo Artists and Facilities
The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program.

H-440.934 Adequacy of Sterilization in Commercial Enterprises
The AMA requests that state medical societies explore with their state health departments the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids.

(MSS Res 3, I-99)

Infant and Child Safety on Airplanes: The MSS formally establishes support for the following HOD policy:

H-45.989 Child Safety Restraint Use in Aircraft
Our AMA supports (1) the use of appropriate restraint systems for all children on all commercial airline flights; and (2) working with the Federal Aviation Administration to establish criteria for appropriate child restraint systems.

(MSS Resolution 13, I-99)

Transparency in Capitation Rate Setting: The MSS formally establishes support for the following HOD policies:

H-180.961 Defining Levels of Health Insurance Coverage
Our AMA strongly encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the Federal Employees Health Benefits Plan program; and supports the enactment of federal and/or state legislation requiring the use by health plans of standardized uniform disclosure formats that have had appropriate input by medical organizations.

H-285.946 Fair Physician Contracts
Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies; (2) which proprietary "correct coding" CPT bundling program is employed; (3) grievance and appeal mechanisms; (4) conditions under which a contract can be terminated by a physician or health plan; (5) patient confidentiality protections; (6) policies on patient referrals and physician use of consultants; (7) a current listing by name and specialty of the physicians participating in the plan; and (8) a current listing by name of the ancillary service providers participating in the plan.

H-185.979 Allocation of Health Services
The AMA will: (1) work with payer organizations and managed care plans and support legislation as necessary to develop and encourage adherence to a standard format across plans for disclosure of relevant plan information to prospective enrollees; (2) expand its consumer information program to develop guides to assist individuals in understanding health insurance offerings and restrictions so that they can make informed decisions in selecting plans best suited to meet individual and family needs and circumstances; (3) utilize all appropriate consumer health information channels to encourage the development by individuals and families of personal health records containing information on family and medical histories and problems, care received, medications, immunizations, allergies, and other relevant medical information and to explore the feasibility of developing sample formats for such personal health records; and (4) encourage and facilitate the development and distribution to physicians for use in their offices of brochures and other appropriate materials that would address such issues as advance directives, health promotions, alternative medical care and other health care information that might be sought by patients and/or their families.

(MSS Resolution 34, I-99)

Physicians as Role Models of Health Maintenance: The MSS formally establishes support for the following HOD policy:

H-170.995 Healthful Lifestyles
The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles.

(MSS Res 8, A-00)
Education Regarding Childhood Obesity: The MSS formally establishes support for the following HOD policy:

H-440.902 Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients.

(MSS Res 11, A-00)

Physician Education Regarding Benefits of Social Group Therapy for Breast Cancer Patients: The MSS formally establishes support for the following AMA policy:

H-55.999 Symptomatic and Supportive Care for Patients with Cancer
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate chemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

(MSS Res 24, A-00)

De-linking Medicaid from Welfare: Room for Improvement: The MSS formally establishes support for the following HOD policy:

H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement
(1) It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs to adult coverage, our American Medical Association urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds. (2) Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable.

(MSS Res 9, A-02)

Protection from Second-Hand Tobacco Smoke at Access Points of Public Buildings: The MSS formally establishes support for the following HOD policy:
H-490.913 Smoke-Free Environments and Workplaces
On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free schools and eliminating smoking in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy lifestyle for children; (d) encourages state or local legislation or regulations that prohibit smoking in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking efforts in the prohibition of smoking in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free environment in the military through the use of mechanisms such as health education, smoking cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking in
their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking in all casinos and gaming venues.

(MSS Res 2, I-02)

Consideration of Humanistic Qualities in Medical School Admissions: The MSS formally establishes support for the following HOD policy:

H-295.888 Progress in Medical Education: The Medical School Admission Process
1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. 2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

(MSS Res 2, A-03)

Bioterrorism Education in the Medical School Curriculum Prior to Clinical Rotations: The MSS formally establishes support for the following HOD policy

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters. (2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts. (3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement
communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post-traumatic stress disorders associated with exposure to disaster, tragedy, and trauma. (4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional’s role in these systems. (5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level. (6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues. (7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters. (8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bio weapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

(MSS Res 6, A-03)

AMA Support for Manned Space Exploration of the Moon, and Mars that will Promote Medical Research and Enhance Patient Care: The MSS formally establishes support for the following AMA policy:
Continuation of Medical Research on Manned Space Flights H-45.994

1. Our AMA supports the continuation of the NASA and other programs for conducting medical research and other research with potential health care benefits on manned space flights, including the continued development and subsequent operation of the international space station. 2. Our AMA (a) publicly supports the National Aeronautics and Space Administration's new commitment for manned space exploration of the moon, Mars, and other celestial bodies for the benefits to medicine and advances in patient care and (b) supports the continuation of NASA research to accomplish safe, human space exploration as this research has demonstrated and may have potential future benefits to medicine and advances in patient care. (Sub. Res. 118, A-86; Modified by Sub. Res. 217, A-94; Reaffirmed: CSA Rep. 6, A-04; Appended and Reaffirmed: Res. 502, A-07)

(MSS Res 7, I-06)

Encouragement of Medicaid Funding for 17P Progesterone for High Risk Pregnancies: The MSS formally establishes support for the following HOD policies:

H-290.993 Coverage of Drugs by Medicaid
Our AMA (1) urges CMS to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions, even if such drugs are manufactured/distributed by non-rebating firms, and (2) asks CMS to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty.

H-420.972 Prenatal Services to Prevent Low Birthweight Infants
Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants.

H-425.976 Preconception Care
1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state: (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan; (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts; (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes; (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact); (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth); (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy; (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low
incomes to improve access to preventive women's health and pre-conception and inter-conception care; (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes; (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health. 2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman’s reproductive health.

(MSS Res 2, I-07)

Decreasing the Spread of HIV/AIDS in the United States: The MSS formally establishes support for the following HOD policy:

D-20.992 Routine HIV Screening
Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 and sexually active adults over 65, (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) supports the Centers for Disease Control and Prevention’s (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (5) will identify legal and funding barriers to the implementation of the CDC’s HIV testing recommendations and develop strategies to overcome these barriers; (6) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and (7) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations.

(MSS Res 7, I-07)

Medical School Tuition Caps and Tuition Freezes to Alleviate the Primary Care Physician Shortage in the U.S.: The MSS formally establishes support for the following HOD policies:

D-305.975 Long-Term Solutions to Medical Student Debt
Our AMA will: (1) through its Council on Medical Education, continue a comprehensive study of medical education financing, with a report back to the House of Delegates at the 2005 Annual Meeting; (2) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (3) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (4) work with state medical societies
to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; and (5) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

H-200.973 Increasing the Availability of Primary Care Physicians
It is the policy of the AMA that: (1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission and set institutional priorities accordingly. (2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties. (3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care. (4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. (5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings. (6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged. (7) Medical schools should provide career counseling related to the choice of a primary care specialty. (8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians. (9) There should be increased financial incentives for physicians practicing primary care. (10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken. (11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. (12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

H-200.997 Primary Care
The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective: (1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged. (2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians. (3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties.

H-305.928 Proposed Revisions to AMA Policy on Medical Student Debt
1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced. 2. Our AMA supports stable funding for medical schools to
eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases. 3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints. 4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance. 5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector. 6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling. 7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment and would permit the full deductibility of interest on student loans. 8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students. 9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.

(MSS Res 5, I-08)

**Interoperable Electronic Medical Records: The Future of a Segmented Health Care System: The MSS formally establishes support for the following HOD policies:**

**D-478.995 National Health Information Technology**

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of EMR user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EMR user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.

(MSS Res 14, I-08)

**Expansion of National Health Services Corps Scholarship and Loan Repayment: The MSS formally establishes support for the following HOD policies:**

**H-200.984 National Health Service Corps Reauthorization**

It is the policy of the AMA: (1) to support legislative efforts to revitalize and reauthorize the NHSC; and (2) to undertake efforts to assure that such legislation include increased funding for recruitment and retention efforts and adequate funding for both the loan repayment and scholarship programs.
H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage
In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) Our AMA encourage medical schools and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

(MSS Res 16, I-08)

Guidelines for the Reuse of Single Use Devices: The MSS formally establishes support for the following HOD policy:

H-480.959 Reprocessing of Single-Use Medical Devices
Our AMA: (1) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000; (2) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry; (3) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and (4) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.

(MSS Res 10, A-09)

Medical Decision Making for Same-Sex Couples: The MSS formally establishes support for the following HOD policy:

H-140.901 Equity in Health Care for Domestic Partnerships
Our AMA supports legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision maker in the absence of an alternative health care proxy designee.

(MSS Res 13, A-09)

**Encouraging Innovative (First in Class) Pharmaceuticals:** The MSS formally establishes support for the following HOD policies:

**H-460.983 Availability of Funding for Research**
(1) Federal funding of basic and applied medical research should be increased at an annual rate of 10 percent (after inflation) for the remainder of the 1980s, and funding in the 1990s should be at a level sufficient to ensure appropriate growth in the nation's biomedical research enterprise. The major recipients of these increases should be the National Institutes of Health, the Veterans Administration, the Alcohol, Drug Abuse and Mental Health Administration, the Food and Drug Administration, and the Centers for Disease Control. (2) The National Institutes of Health, the Alcohol, Drug Abuse and Mental Health Administration, and other granting agencies should fund 40 percent of the approved grant applications each year for the remainder of the 1980s. (3) Appropriate measures to reform patent, tax and licensing laws, as well as measures to enhance the efficiency of regulatory processes, should be adopted by the federal government to encourage private industry involvement in basic and applied biomedical research.

**H-110.996 Cost of Prescription Drugs**
Our AMA supports increasing physician awareness about the cost of drugs prescribed for their patients.

(MSS Res 14, A-09)

**Condoms in Prisons:** The MSS formally establishes support for the following HOD policy:

**H-430.988 Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities**
(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes mandatory testing for HIV infection and tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Testing for HIV infection and tuberculosis should be mandatory for all prisoners within 60 days of their release from prison; e) Physicians who practice in correctional institutions should evaluate all tuberculin-positive inmates for HIV infection and all HIV-positive patients for tuberculosis, since HIV status may affect subsequent management of tuberculosis infection or disease and tuberculosis may accompany HIV infection; f) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; g) During their post-test counseling procedures, prison medical directors should encourage HIV-infected inmates to confidentially notify their sexual or needle-sharing partners; and h) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention
information as a regular part of correctional staff and inmate education. AIDS education in state
and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well
as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue
legislation that encourages state, local, and federal correctional institutions to make condoms
available to inmates; and c) Urges medical personnel in correctional institutions to work closely
with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis,
and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV
Partner Notification Program Our AMA: a) Urges state health departments to take steps to
initiate with state departments of correctional services the development of prison-based HIV
Partner Notification Programs for inmates convicted of drug-related crimes and their regular
sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in
an HIV Partner Notification Program will depend on the truly voluntary participation of inmates
and the strict observance of confidentiality at all levels.

(MSS Res 17, A-09)

Rethinking AMA Medical Liability Reform Policy: The MSS formally establishes support for the
following HOD policy:

(1) It is the policy of the AMA that effective medical liability reform, based on the California
Medical Injury Compensation Reform Act (MICRA) model, is integral to health system
reform. The AMA’s MICRA-based federal tort reform provisions include: (a) a $250,000
ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff
compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d)
periodic payment of future awards of damages, and (e) a limitation on the period for
suspending the application of state statutes of limitations for minors to no more than six years
after birth. (2) Our AMA also supports federal reform to achieve: (a) a certificate of merit
requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline
expert witness qualifications; and (c) demonstration projects to implement potentially effective
alternative dispute resolution (ADR) mechanisms. (3) Our AMA supports medical product
liability reform, applicable to the producers of pharmaceuticals and medical devices, as an
important state and federal legislative reform objective. (4) Any health system reform proposal
that fails to include MICRA type reform, or an alternative model proven to be as effective in a
state, will not be successful in containing costs, providing access to health care services, and
promoting the quality and safety of health care services. Under no circumstances would
support for federal legislation be extended or maintained if it would undermine effective tort
reform provisions already in place in the states. Federal preemptive legislation that endangers
effective state-based reform will be actively opposed.

(MSS Res 14, A-10)

Reevaluation of Elderly Drivers: The MSS formally establishes support for the following HOD policies:

H-15.972 Licensing People to Drive
It is the policy of the AMA (1) to encourage research into the many components and activities
of the driving task and into the development of more accurate testing devices; (2) that
physicians continue to warn patients about the possibility of untoward side effects from
medications, particularly those that might impair driving; (3) that the physician attempt to give
competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and (4) that the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test.

H-15.954 Older Driver Safety
(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual's driving capabilities, and: (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual's driving performance, and counsel and manage their patients accordingly; (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient's driving safety cannot be maintained through medical interventions or driver rehabilitation; (c) urges physicians to know and adhere to their state's reporting statutes for medically at-risk drivers; and (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting. (2) Our AMA encourages physicians to use the Physician's Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.

(MSS Res 21, A-10)

Expanding Graduate Medical Education in Response to the Increase in Medical Student Training: The MSS formally establishes support for the following HOD policies:

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
It is AMA policy that: (1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. (2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. (3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. (4) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. (5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding. (6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. (7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources,
including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. (9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties

H-310.917 Securing Funding for Graduate Medical Education
Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.

(MSS Res 8, I-10)

Medical Student Position Regarding the 2010 ACGME Residency Work Standards: The MSS formally establishes support for the following HOD policy:

H-310.979 Resident Physician Working Hours and Supervision
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution’s GME Committee must [m]onitor programs’ supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents’ access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents’ work that is extraneous to their GME programs’ educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for
supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities." (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.

(MSS Res 15, I-10)

Opposing Mandatory Treatment of Patients Covered by Government-Funded Health Insurance as a Condition of Physician Licensure: The MSS formally establishes support for the following HOD policies:

H-275.994 Physician Participation in Third Party Payer Programs
The AMA opposes state laws making a physician's licensure contingent upon his providing services to Medicaid beneficiaries or any other specific category of patients should be opposed.

H-275.984 Legislative Action
The AMA (1) vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount; (2) strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and (3) opposes any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure.

D-275.962 Threat to Medical Licensure
Our AMA will develop model legislation to ensure that medical licensure is independent of participation in any health insurance program.

(MSS Res 19, I-10)

Awareness, Diagnosis, and Treatment of Bipolar Disorder in Youth: The MSS formally establishes support for the following HOD policies:

H-345.981 Access to Mental Health Services
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person’s identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

(MSS Res 21, I-10)
Creating National Standards for Electronic Health Records Systems: The MSS formally establishes support for the following HOD policies:

D-478.996 Information Technology Standards and Costs
Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

D-478.994 Health Information Technology
Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; and (3) support initiatives to ensure interoperability among all HIT systems.

(MSS Res 23, I-10)

AMA Support of Medical Supply Reuse Programs: The MSS formally establishes support for the following HOD policies:

D-250.992 Medical Supply Donations to Foreign Countries
Our AMA will: (1) continue to advertise opportunities for donations on the AMA web site and continue to refer individual physicians to appropriate relief agencies; and (2) continue current relationships with relief organizations.

H-65.994 Medical Care in Countries in Turmoil
The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

H-250.987 Duty-Free Medical Equipment and Supplies Donated to Foreign Countries
Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries.
Putting Price Transparency into Practice: The MSS formally establishes support for the following HOD policy:

H-373.998 Patient Information and Choice

Our AMA supports the following principles: (1) Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. (2) Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. (3) In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees’ information on the amount of payment provided toward each type of service identified as a covered benefit. (4) Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. (5) Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. (6) Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

Promoting the Universal Adoption of Electronic Prescription Systems: The MSS formally establishes support for the following HOD policy:

D-120.958 Federal Roadblocks to E-Prescribing

1. Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form; 2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs; 3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-Prescribing; 4. Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions; 5. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.
Support of Outreach Programs that Utilize Community Leaders to Deliver Culturally-Competent Health Information: The MSS formally establishes support for the following HOD policies:

H-205.997 AMA Statement on Voluntary Health Planning

Our AMA believes that the following principles should be considered in the creation and implementation of a program of voluntary community health planning: (1) Health planning should be the primary function of a collaborative group of community organizations and interested individuals. While a variety of structural modalities may be considered to implement this function, the most common is the creation of an eleemosynary organization by the community to be served. However structured and financed, this "health planning organization" should be created from the mandate of the community to address health needs and priorities in a structured fashion and should be legally incorporated to perform this function. (2) The planning organization must be representative of the community and have the active support and participation of the community to be served, including but not limited to physicians. The proper mix of the participants should be determined by the community served and should be responsive to the priorities of the community. (3) As an entity representing the community-at-large, the planning organization should exhibit the following characteristics: thoroughness, objectivity, integrity, sensitivity to the interests of the community; understanding of health care delivery systems and financing; and accountability to the community served. (4) The planning organization should assume an active positive role in assessing community health and medical needs and should serve as the community's advocate in meeting those needs. The recommendations of the organization should be advisory and the responsibility for implementing those recommendations should rest with the institutions and entities most directly involved. (5) The organization should serve in an informational and educational role to the community-at-large on such issues as community health status, health care financing, health care costs, and the availability of local health resources. Periodic reports should be provided to the community on these and other significant health care issues. (6) The size and scope of the geographic area to be served is best determined by the community residents based on analysis of such factors as population density, service area of health care institutions and practitioners, geographic and transportation considerations, and should not be arbitrarily defined by existing political boundaries. Regional considerations involving two or more such local planning areas may be best coordinated through a consortium of the local planning organizations as appropriate. (7) The planning organization should function under a constitution and bylaws which, at a minimum, set forth: (a) the major objectives of the organization; (b) a locally accepted process for the election, selection and/or appointment of members to the governing body; (c) a mechanism to preserve account-ability to the community-at-large for the recommendations and actions of the organization, recognizing the accepted principles of confidentiality; and (d) a mechanism for ongoing evaluation of all aspects of the organization's services to the community. (8) Decisions regarding the employment of professional consultants and/or staff are properly those of the governing body of the local organization based on the scope of its activities and financial viability. (9) There should be a substantial commitment from the community-at-large to supporting and financing the operation of the planning organization. This commitment may be expressed through donations of public funds, private funds and general solicitation. Donations of time and expertise may be quite substantive and should be recognized equivalently as community contributions. (10) Government may provide supplemental funding in support of local health planning activities directed toward meeting locally determined goals and objectives. Such supplemental financial assistance from government sources should not diminish or replace the financial or other substantive support of the community. Such supplemental funding should not
be accepted without careful consideration of the obligations which may accompany it and a commitment to achieve sufficiency as early as possible. (11) The planning organization should encourage and promote the development of positive incentives to attain the objectives identified by the community and should not have regulatory authority or responsibilities. (12) The protection of the public welfare is properly a concern of government and activities to protect the public may be implemented in a variety of ways. However, local voluntary health planning is a creative process and, therefore, should not include the use of regulatory sanctions. (13) Exemption from the antitrust laws should be sought for actions taken to implement recommendations of the planning organization, in furtherance of the objectives identified and approved by the community through the planning process.

(MSS Res 32, I-10)

Testing and Lengthening Drug Expiration Dates: The MSS formally establishes support for the following HOD policy:

H-115.983 Expiration Dates and Beyond-Use Dates of Prescription Drug Products Our AMA: (1) supports the inclusion of expiration dates on the containers/labels of prescription drug products and recommends that expiration dates be determined by pharmaceutical manufacturers using scientifically based stability testing with subsequent approval by the Food and Drug Administration (FDA); (2) urges the pharmaceutical industry, in collaboration with purchasers, the FDA, and the United States Pharmacopeia (USP), to determine whether lengthening of expiration dates will provide clinical and/or economic benefits or risks for patients and, if this is the case, to conduct longer stability testing on their drug products; (3) recommends that pharmacists place a beyond-use date on the labeling of all prescription medications dispensed to patients, and that the beyond-use date be based on the recommendations in the most recent edition of the United States Pharmacopeia and National Formulary (currently USP 24-NF 19) (official January 1, 2000); and (4) encourages the USP, in collaboration with pharmaceutical manufacturers, pharmacy organizations, and the FDA, to continue to explore the development of appropriate stability tests for the determination of scientifically sound beyond-use dates for repackaged products.

(MSS Res 42, I-10)

Broader Regulation of Direct-to-Consumer Genetic Testing: The MSS formally establishes support for the following HOD policies:

H-460.908 Genomic-Based Personalized Medicine Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians’ voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing
Our AMA: (1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

(MSS Res 45, I-10)

Promoting a Standard Nutrition Education Curriculum for Primary and Secondary School Age Children:
The MSS formally establishes support for the following HOD policies:

H-150.996 Nutrition Courses in Medicine
Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools.

H-150.953 Obesity as a Major Public Health Program
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
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Self-Injectable Epinephrine Preparedness in Response to Anaphylaxis: The MSS formally establishes support for the following HOD policies:

H-440.884 Food Allergic Reactions in Schools and Airplanes
Our AMA recommends that all: (1) schools provide increased student and teacher education on the danger of food allergies; (2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and (3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use.

D-60.976 Childhood Anaphylactic Reactions
Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy and Anaphylaxis Network; and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

(MSS Res 27, A-11)

Improving Access to Subsidized Graduate Student Loans: The MSS formally establishes support for the following HOD policy:

D-305.993 Medical School Financing, Tuition, and Student Debt
(1) The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes. (2) Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that
provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts. (3) Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. (4) Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students. (5) Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians. (6) Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians. (7) Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.

(MSS Res 7, I-11)

Protecting the Doctor-Patient Relationship: The MSS formally establishes support for the following HOD policy:

H-373.995 Government Interference in Patient Counseling
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients. 2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients. 3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

(MSS Res 18, I-11)

Closer Monitoring of Emergency Medical Kits on Passenger Aircrafts: The MSS formally establishes support for the following HOD policy:

H-45.981 Improvement in US Airlines Aircraft Emergency Kits
Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.

(MSS Res 28, I-11)
Reducing Second-Hand Smoke in Apartment Complexes: The MSS formally establishes support for the following HOD policy:

H-490.907 Tobacco Smoke Exposure of Children in Multi-Unit Housing
Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking adults from tobacco smoke exposure by prohibiting smoking in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking adults from tobacco smoke exposure by prohibiting smoking in multi-unit housing.

(MSS Res 39, I-11)

Physician Position to Novel Tobacco Markets: The MSS formally establishes support for the following HOD policies:

H-495.985 Smokeless Tobacco
Given that the use of smokeless tobacco (snuff and chewing tobacco) is associated with health risks, our AMA: (1) supports publicizing the increasing evidence that the use of snuff or chewing tobacco is associated with adverse health effects and encourages ongoing research to further define the health risks associated with snuff and chewing tobacco, including the risk of developing cardiovascular disease, and the effectiveness of cessation and prevention programs; (2) objects strongly to the introduction of "smokeless" cigarettes; (3) opposes the use of smokeless tobacco products by persons of all ages; (4) urges that the same requirements and taxes placed on cigarette sales and advertising be applied to smokeless tobacco products; (5) supports legislation to prohibit the sale of smokeless tobacco products to minors and encourages states to enforce strictly the prohibition on purchasing and distributing all tobacco products to individuals under the age of 21 years; (6) supports public and school educational programs on the health effects of smokeless tobacco products; (7) urges the commissioner of professional athletic organizations to discourage the open use of smokeless tobacco by professional athletes and recommends that professional athletes participate in media programs that would discourage the youth of America from engaging in this harmful habit; and (8) is committed to exerting its influence to limit exposure of young children and teenagers to advertising for smokeless tobacco and look-alike products, and urges that manufacturers take steps to diminish the appeal of snuff and chewing tobacco to young persons.

H-495.987 Tobacco Taxes
(1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to pass increased federal, state, and local excise taxes on tobacco in order to discourage tobacco use. (2) An increase in federal, state, and local excise taxes for tobacco should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. (3) Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.

(MSS Res 40, I-11)
Comprehensive Women’s Healthcare for Professionals during Training: The MSS formally establishes support for the following HOD policies:

H-295.872 Expansion of Student Health Services
1. It is AMA policy that medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring. 2. Our AMA will encourage the Liaison Committee on Medical Education to develop an annotation to its standard on medical student access to preventive and therapeutic health services that includes a specification of the following: a. Medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring. b. Medical students should have information about where and how to access health services at all locations where training occurs. c. Medical schools should have policies that permit students to be excused from class or clinical activities to seek needed care.

H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians:
The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

(MSS Res 5, A-12)

Reimbursement for Addressing Social Determinants of Health in Primary Care: The MSS formally establishes support for the following HOD policy:
H-160.919 Principles of the Patient-Centered Medical Home

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.

Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement. It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
It should recognize case mix differences in the patient population being treated within the practice.
It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.
3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.
4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.
5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

(MSS Res 11, A-12)

Cost Transparency through Clinical Report Documentation: The MSS formally establishes support for the following HOD policy:

H-185.975 Requiring Third Party Reimbursement Methodology be Published for Physicians
Our AMA: (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules; (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans; (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted. (4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies; (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and (6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.

(MSS Res 15, A-12)

Cancer Screenings to Reduce Health Disparities: The MSS formally establishes support for the following HOD policies:

D-350.996 Strategies for Eliminating Minority Health Care Disparities
Our American Medical Association: (1) commend the Institute of Medicine (IOM) on its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and that all applicable AMA Councils be requested to formally review the IOM report and its recommendations and submit reports back to the AMA House of Delegates at the 2003 Interim Meeting from their areas of expertise with specific strategies to move towards the elimination of racial and ethnic health care disparities; and (2) identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

(MSS Res 27, A-12)

**Tax Deductions for State Based Health Insurance Exchange Policies:** The MSS formally establishes support for the following HOD policies:

- **H-165.848 Individual Responsibility to Obtain Health Insurance**
  1. Our AMA will support a requirement that individuals and families earning greater than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.
  2. Upon implementation of a system of refundable, advanceable tax credits inversely related to income or other subsidies to obtain health care coverage, our AMA will support a requirement that individuals and families earning less than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.

(MSS GC Rep C, A-12)

**Recommending Modified Regulation on Direct-to-Consumer Advertising of Drugs:** The MSS formally establishes support for the following HOD policy:

- **H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices:**
  It is the policy of our AMA: 1. That our AMA considers acceptable only those product-specific DTC advertisements that satisfy the following guidelines: (a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device and the disease, disorder, or condition for which the drug or device is used. (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug’s or device’s approval for marketing. (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products. (d) The advertisement should not encourage self-diagnosis and self-treatment but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended. (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable. (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without
distraction of content, and will help facilitate communication between physician and patient. (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition. (h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed. (i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement. (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved. (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines. 2. That our AMA opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines. 3. That the FDA review and pre-approve all DTC advertisements for prescription drug or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product. 4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTC. 5. That DTC advertisements for newly approved prescription drug or implantable medical device products not be run until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTC for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product’s sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it. 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTC advertisements. 7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTC, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public. 8. That our AMA supports the concept that when companies engage in DTC, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine. 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTC and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion. 10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) to perform periodic evidence-based reviews of DTC in the United States to determine the impact of DTC on health outcomes and the public health. If DTC is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTC regulation or, if necessary, to prohibit DTC in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution. 11. That our AMA continues to monitor DTC, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTC, as necessary. 12. That our AMA supports "help-seeking" or "disease
awareness” advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA). (BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07)

Eliminating Health Care Disparities for Children with Special Health Care Needs: The MSS formally establishes support for the following HOD policies:

H-165.855 Medical Care for Patients with Low Incomes
It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children’s Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy) (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12)

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children’s Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid
programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care...
care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children’s Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. (BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11)

(MSS Res 28, I-12)

National Institutes of Health and National Science Foundation Funding after Sequestration: The MSS formally establishes support for the following HOD policy:

H-460.926 Funding of Biomedical, Translational, and Clinical Research
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research. (Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10)

(MSS Res 1, A-13)

Support for Non-Addictive Nicotine Content Levels in Cigarettes: The MSS formally establishes support for the following HOD policy:

H-495.988 FDA Regulation of Tobacco Products
Our AMA: (1) reaffirms its position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette; (2) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (3) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (4) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (5) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (6) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; (7) encourages the FDA to assert its authority over the manufacture of tobacco products to reduce their addictive potential at the earliest practical time, with a goal for implementation within 5-10 years; and (8) strongly opposes legislation which would
undermine the FDA’s authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA’s authority to regulate tobacco products. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12)

(MSS Res 19, A-13)

**Preventing Violent Intent Trauma Recidivism:** The MSS formally establishes support for the following HOD policies:

- **H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care**
  1. Our AMA supports: 1) federal and state research on firearm-related injuries and deaths; 2) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; 3) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; 4) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; 5) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; and 6) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. (Sub. Res. 221, A-13)

- **H-515.979 Violence as a Public Health Issue**
  The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. (Sub. Res. 408, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13)

(MSS Res 2, I-13)

**Over-the-Counter Access to Oral Contraceptives:** The MSS formally establishes support for the following HOD policies:

- **D-75.995 Over-the-Counter Access to Oral Contraceptives**
  1. Our AMA will recommend to the US Food and Drug Administration that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence for the Agency to consider approving a switch in status from prescription to over-the-counter for such products. 2. Our AMA encourages the continued study of issues relevant to over-the-counter access for oral contraceptives. (Sub. Res. 507, A-13)

- **H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools**
  Our AMA: (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) show promise for delaying the onset of
sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (c) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (d) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (e) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (f) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy. (CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09)

(MSS Res 4, I-13)

Shared Medical Appointments - A Novel Healthcare Model: The MSS formally establishes support for the following HOD policy:

H-160.911 Value of Group Medical Appointments
Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy. (Res. 713, A-13)

(MSS Res 7, I-13)

Eliminating Nonclinical Antibiotic Usage in Livestock: The MSS formally establishes support for the following HOD policies:

D-100.976 Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance
Our AMA will work with interested partners to develop new, or improve existing, FDA guidelines concerning the prudent use of antibiotics in livestock to protect patients from the dangers of antimicrobial resistant pathogens. (Res. 530, A-08)
Prevention and Awareness of In-Flight Syncope: The MSS formally establishes support for the following HOD policies:

H-45.979 Air Travel Safety
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; and (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency. (CSA Rep. 5, I-98; Appended: CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-45.978 In-flight Medical Emergencies
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure: (a) rapid 24-hour access to qualified emergency medical personnel on the ground; (b) at a minimum, voice communication with qualified ground-based emergency personnel; (c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies; (d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form; (e) adequate medical supplies and equipment aboard aircraft; (f) routine flight crew safety training; (g) periodic assessment of system quality and effectiveness; and (h) direct supervision by physicians with appropriate training in emergency and aerospace medicine. (CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-45.983 Medical Oxygen Therapy on Scheduled Commercial Air Service
Our AMA (1) supports the accommodation of passengers requiring medical oxygen therapy on scheduled commercial aircraft and in airports; (2) recommends that regulatory agencies, medical specialty societies, commercial air carriers, airport authorities, and other interested parties develop a coordinated system, with uniform guidelines specifying acceptable procedures and equipment for the use of medical oxygen in airports and aboard commercial aircraft, that will permit passengers to schedule oxygen with the least possible administrative and financial difficulty and to have available to them an uninterrupted source of oxygen from departure to destination; and (3) urges that any revised system to improve the accommodation of passengers requiring medical oxygen ensure the safety and security of other airline passengers and airport personnel. (Res. 519, A-95; Amended CSA Rep. 4, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

Physician Attire Autonomy: The MSS formally establishes support for the following HOD policy:
H-440.856 Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease
Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume “antimicrobial stewardship,” i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care. (BOT Rep. 3, A-10)

(MSS Res 33, I-13)

Increasing Healthy Food Options in School Lunches for Elementary and Middle School Students: The MSS formally establishes support for the following HOD policies:

H-150.944 Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13)

H-150.962 Quality of School Lunch Program
The 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. (Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07)

(MSS Res 40, I-13)

AMA Support for Medical Students, Residents, and Faculty Who Provide Breastmilk After Reentry into the Workplace: The MSS formally establishes support for the following HOD policy:

H-245.982 AMA Support for Breastfeeding
(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2005 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. (2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding
policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

(MSS Res 23, A-14)

Safety Net Hospitals and Need for Disproportionate Share Hospital Funding: The MSS formally establishes support for the following HOD policy:

D-215.995 Specialty Hospitals and Impact on Health Care
Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities; and (6) continue to monitor the specialty hospital issue and report back to the House of Delegates at the 2005 Annual Meeting. (BOT Rep. 15, I-04; Reaffirmation A-09)

(MSS Res 24, A-14)

AMA Study on Risk-Based Interest Rates for Federal Student Loans and Creation of “Medical Student” Category in Federal Direct Student Loan Program: The MSS formally establishes support for the following HOD policy:

D-305.984 Reduction in Student Loan Interest Rates
1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program. (Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13)

(MSS Res 1, I-14) (MSS Res 11, I-14)
Educating America on Graduate Medical Education: The MSS formally establishes support for the following HOD policy:

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation’s current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare & Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program’s sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (A) train more physicians to meet state and regional workforce needs; (B) train physicians who will practice in physician shortage/underserved areas; or (C) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.


(MSS Res 2, I-14)

Expanding Supportive Efforts in Pre-K-12 Education for Minorities: The MSS formally establishes support for the following HOD policies:

H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession

Our AMA supports increasing the representation of minorities in the physician population by:
(1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that
offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

(MSS Res 27, I-14)

H-170.985 Science, Technology, Engineering and Mathematics Education
Our AMA is committed to working with other concerned organizations and agencies to improve science, technology, engineering and mathematics (STEM) education and literacy in the nation, and to increase interest in STEM on the part of the nation's youth, particularly underrepresented minorities. (Res. 2, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 514, A-09; Reaffirmed in lieu of Res. 524, A-09; Modified: Res. 516, A-14)

(MSS Res 4, I-14)

Responding to the Global Drug-Resistant Tuberculosis Pandemic: The MSS formally establishes support for the following HOD policy:

H-440.874 Support of Legislation Regarding Global and Domestic Tuberculosis Control Our AMA supports federal legislation to increase resources for global and domestic TB control. (Res. 227, A-07)

(MSS Res 8, I-14)

Advocating for the Further Research and Clinical Implementation of the States of Change Model in Lifestyle Counseling to Fight Obesity: The MSS formally establishes support for the following HOD policy:

H-425.972 Healthy Lifestyles
Our AMA: (1) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (2) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (3) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to
routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management. (Res. 423, A-12)

(MSS Res 19, I-14)

NIH Initiatives for Young Researchers: The MSS formally establishes support for the following HOD policy:

H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers Our AMA: (1) continues its strong support for the Medical Scientists Training Program’s stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00; Reaffirmed: CME Rep. 14, A-09)

(MSS Res 32, I-14)

Advocating for Optimal Screening and Management of Human Trafficking Victims by Formal Education of Healthcare Professionals on this Issue through Integration of this Topic into Continuing Medical Education Requirements and Undergraduate Medical Curriculum throughout the USA: The MSS formally establishes support for the following HOD policy:

H-65.966 Physicians Response to Victims of Human Trafficking Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it’s difficult to know just how extensive the problem of human trafficking is, it’s estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children. The Polaris Project - In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the
Polaris Project: - Operates a 24-hour National Human Trafficking Hotline - Maintains the National Human Trafficking Resource Center, which provides a. An assessment tool for health care professionals b. Online training in recognizing and responding to human trafficking in a health care context c. Speakers and materials for in-person training d. Links to local resources across the country
The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department’s Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals. (BOT Rep. 20, A-13)

(MSS Late Res 8, I-14)

Optimizing Health Care Cost Reduction through Sustainability Education and Implementation: The MSS formally establishes support for the following HOD policy:

H-135.939 Green Initiatives and the Health Care Community
Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of “green” initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10)

(MSS Res 8, A-15)

FDA Clinical Trial Misconduct Reporting and Transparency: The MSS formally establishes support for the following HOD policies:

H-460.972 Fraud and Misrepresentation in Science
The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11)
D-460.970 Access to Clinical Trial Data
Our AMA: (1) urges the Food and Drug Administration to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; and (2) supports the adoption of universal policy by medical journals requiring participating investigators to have independent access to all study data from industry-sponsored trials. (Res. 503, A-14)

(MSS Res 10, A-15)

Addressing Sexual Violence and Improving American Indian and Alaska Native Women’s Health Outcomes: The MSS formally establishes support for the following HOD policies:

H-350.976 Improving Health Care of American Indians
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life. (4) American Indian religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (CLRDP Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

H-350.977 Indian Health Service
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian
Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

H-350.981 AMA Support of American Indian Health Career Opportunities
AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population. (4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)

(MSS Res 15, A-15)

Support for Mandatory Vaccination: The MSS formally establishes support for the following HOD policy:
H-440.970 Religious Exemptions from Immunizations
Since religious/philosophic exemptions from immunizations endanger not only the health of the unvaccinated individual, but also the health of those in his or her group and the community at large, the AMA (1) encourages state medical associations to seek removal of such exemptions in statutes requiring mandatory immunizations; (2) encourages physicians and state and local medical associations to work with public health officials to inform religious groups and others who object to immunizations of the benefits of vaccinations and the risk to their own health and that of the general public if they refuse to accept them; and (3) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in exempt populations and to intensify efforts to achieve high immunization rates in communities where groups having religious exemptions from immunizations reside. (CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

(MSS Res 21, A-15)

Expansion of Medicaid: The MSS formally establishes support for the following HOD policy:

H-290.966 Medicaid Expansion Options and Alternatives
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap. 2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low-income adult populations. 3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. 4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.

(CMS Rep. 5, I-14)

(MSS Res 26, A-15)

Advocating for Research to Improve the Effectiveness of Nutrition Labeling at Restaurant Chains: The MSS formally establishes support for the following HOD policy:

H-150.936 Support for Uniform, Evidence-Based Nutritional Rating System
1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers’ purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making. 2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria. (Res. 424, A-10)
H-490.917 Physician Responsibilities for Tobacco Cessation

Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA:

1. encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products;
2. supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth;
3. encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health;
4. (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work; (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician;
5. (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs;
(6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and

(7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence. (CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08; Reaffirmed in lieu of Res. 912, I-12)

(MSS Res 44, A-15)

Supporting the Incorporation of Community-Based Early Detection, Treatment, and Prevention of Psychosis into Mental Health Systems: The MSS formally establishes support for the following HOD policy:

D-345.994 Increasing Detection of Mental Illness and Encouraging Education
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12)

(MSS Res 49, A-15)

Vision Screening before Entering School: The MSS formally establishes support for the following HOD policy:

H-425.977 Encouraging Vision Screenings for Schoolchildren Our AMA:
(1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment;
(2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and
(3) supports periodic pediatric eye screenings based on American Academy of Pediatrics, American Academy of Family Physicians and American Academy of Ophthalmology evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. (Res. 430, A-05)

(MSS Res 53, A-15)
Ensuring High Quality Care for All Veterans and Their Families: The MSS formally establishes support for the following HOD policies:

H-510.985 Access to Health Care for Veterans
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans’ health care to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program’s "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation’s veterans.(Sub. Res. 111, A-15)

H-510.991 Veterans Administration Health System
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.(CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

H-510.995 Budgetary and Management Needs of the Veterans Health Administration
Our AMA urges Congress and the President to provide the VHA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the VHA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals.(BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)

D-510.999 Veterans Health Administration Health Care System
Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient’s health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA’s payment for prescriptions written by physicians who have no formal affiliation with the VHA.(CMS Rep. 1, A-03; Reaffirmed: CMS Rep. 4, A-13)

H-510.994 Ethics Reform Act of 1989
It is the policy of the AMA to work with representatives of [the] Central Office, Department of Veterans Affairs, to develop provisions to exclude either by regulation or by legislation part-time Department of Veterans Affairs physicians (as well as attending and consulting
physicians) from the provisions of the Ethics Reform Act of 1989. (Res. 254, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

(MSS Res 19, I-15)

Drug Pricing Reform: The MSS formally establishes support for the following HOD policies:

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

H-110.989 Pay for Delay Arrangements by Pharmaceutical Companies
Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.(Res. 520, A-08; Appended: Res. 222, I-12)

D-330.954 Prescription Drug Prices and Medicare
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.(Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14)

(MSS Res 21, I-15)

Youth Health Pipeline Programs Initiative: The MSS formally establishes support for the following HOD policies:

D-200.982 Diversity in the Physician Workforce and Access to Care
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.(CME Rep. 7, A-08; Reaffirmation A-13)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-under served areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. (CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14)

D-350.995 Reducing Racial and Ethnic Disparities in Health Care
Our AMA’s initiative on reducing racial and ethnic disparities in health care will include the following recommendations: (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care. (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03; Reaffirmation A-11)

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

H-350.960 Underrepresented Student Access to US Medical Schools
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students. (Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

H-350.968 Medical School Faculty Diversity
Our AMA encourages increased recruitment and retention of faculty members from underrepresented minority groups as part of efforts to increase the number of individuals from underrepresented minority groups entering and graduating from US medical schools. (CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09)

H-350.970 Diversity in Medical Education
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.(BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

H-350.978 Minorities in the Health Professions
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.(CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

(MSS Res 27, I-15)

Increasing Access to Medical Devices for Insulin-Dependent Diabetics: The MSS formally establishes support for the following HOD policy:

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

Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. (Res. 126, A-14)

(MSS Res 04, A-16)

Removing Restrictions on Federal Funding for Firearm Violence Research: The MSS formally establishes support for the following HOD policies:

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level. (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm-related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System. (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Epidemiology of Firearm Injuries D-145.999
Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms. (Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)

(MSS Res 16, A-16)

Support for Equal Healthcare Access for Eating Disorders: The MSS formally establishes support for the following HOD policy:

Eating Disorders H-150.965
The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and

(MSS Res 20, A-16)

**Gun Violence as a Public Health Crisis:** The MSS formally establishes support for the following AMA policy:

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

(Late Res 1011, A-16)

**Decreasing Polypharmacy Among Elderly Patients:** The MSS formally establishes support for the following HOD policy:

Improving the Quality of Geriatric Pharmacotherapy H-100.968
Our AMA believes that the Food and Drug Administration should encourage manufacturers to develop low dose formulations of medications commonly used by older patients in order to meet the special needs of this group; require geriatric-relevant labeling for over-the-counter medications; provide incentives to pharmaceutical manufacturers to better study medication effects in the frail elderly and oldest-old in pre- and post-marketing clinical trials; and establish mechanisms for data collection, monitoring, and analysis of medication-related problems by age group. (CSA Rep. 5, A-02; Reaffirmation A-10)

(MSS Res 23, I-16)

**Addressing Physician and Patient Gaps in Opioid Education:** The MSS formally establishes support for the following HOD policies:

Protection for Physicians Who Prescribe Pain Medication H-120.960
Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice; and 2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management. (Sub. Res. 508, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 515, A-14; Reaffirmed: BOT Rep. 14, A-15)

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices: A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students. B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms. 2. Our AMA: A. promotes physician training and competence on the proper use of controlled substances; B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients; C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances. 3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities. 4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 907, I-11; Appended: Res. 219, A-12; Reaffirmation A-15; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

(MSS Res 24, I-16)
Informed Consent for Medical School Applicants: Addressing Medical Student Applicant’s Understanding of Burnout: The MSS formally establishes support for the following HOD policy:

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students. 2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. 3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. 4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. 5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements. 6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout. (CME Rep. 8, A-07; Modified: Res. 919, I-11)

(MSS Res 26, I-16)

AMA-MSS Support of the Movement for Black Lives: The MSS formally establishes support for the following HOD policy:

Racial and Ethnic Disparities in Health Care H-350.974
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association. The AMA emphasizes three approaches that it believes should be given high priority: (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our
AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12

(MSS Res 27, I-16)

Ultrasound Education in Preclinical Curricula: The MSS formally establishes support for the following HOD policy:

Diagnostic Ultrasound Utilization and Education H-480.950
Our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. (Res. 507, A-12)

(MSS Res 29, I-16)

Non-Behavioral Methods of Diabetes Prevention in At-Risk Populations: The MSS formally establishes support for the following HOD policies:

Expansion of National Diabetes Prevention Program H-440.844
Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. (Sub. Res. 911, I-12)

Strategies to Increase Diabetes Awareness D-440.935
Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence. (Res. 412, A-13)

(MSS Res 33, I-16)

Integration of Telemedicine into Medical Education: The MSS formally establishes support for the following HOD policy:

Telemedicine in Medical Education D-295.313

1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. 3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training. (CME Rep. 06, A-16)

(MSS Res 39, I-16)

Encouraging Lifestyle Medicine in Undergraduate Medical Education: The MSS formally establishes support for the following HOD policy:
Health Information and Education H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted. (2) Employers should provide, and employees should participate in programs on health awareness, safety and the use of health care benefit packages. (3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite. (4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse. (5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities. (6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care. (7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community. (8) Information on health and health care should be presented in an accurate and objective manner. (9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula. (10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market. (11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs. (12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services. (13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15)

(MSS Res 41, I-16)

Human Rights as the Foundation of Public Health: The MSS formally establishes support for the following HOD policy:

World Health Organization H-250.992

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization.

(MSS Res 19, A-17)

**Economic Sustainability and Improved Usage of Health Information Exchanges:** The MSS formally establishes support for the following HOD policies:

Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities D-478.981

Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits. (Res. 827, I-10; Reaffirmed: 1-13)

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Health Information Technology H-478.994
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.

Information Technology Standards and Costs D-478.996 Our AMA will:
(1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;
(2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;
(3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;
(4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and
(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

(MSS Res 25, A-17)

Increase Access to HIV PrEP for At-Risk Individuals: The MSS formally establishes support for the following HOD policy:

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

(MSS Res 26, A-17)

Protecting the Integrity of Phase III Clinical Trials: The MSS formally establishes support for the following HOD policies:

FDA H-100.992
(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or post-market incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and post-market reports shows that the drug is unsafe and/or ineffective for its labeled indications.

(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10)

FDA Drug Safety Policies D-100.978
Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. (Sub. Res. 505, A-08; Reaffirmation A-16)

Food and Drug Administration H-100.980
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate. (Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07; Reaffirmed: Sub. Res. 504, A-10; Reaffirmation A-15; Reaffirmed: CMS Rep. 06, I-16)

(MSS Res 32, A-17)

Promoting Education on How to Evaluate Asylum Seekers for Signs of Physical and/or Psychological Torture: The MSS formally establishes support for the following HOD policies:

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation,
gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. (CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17)

Human Rights H-65.997

Human Rights and Health Professionals H-65.981

(MSS Res 48, A-17)

Review of AMA-MSS Statements of Support for HOD Policies: The MSS formally establishes support for the following HOD policies:

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845
Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their
physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. (CCB/CLRDP Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17)

Umbilical Cord Blood Transplantation: The Current Scientific Understanding H-370.961
Our AMA will: (1) encourage continued research into the scientific issues surrounding the use of umbilical cord blood-derived hematopoietic stem cells for transplantation, including the ex vivo expansion of umbilical cord blood-derived hematopoietic stem cells; the combination of multiple units of closely matched, unrelated umbilical cord blood cells for transplantation; and the improvement of umbilical cord blood cells collection techniques; and
(2) support education for physicians and the public about the potential benefits of, and limitations to, umbilical cord blood transplantation as an alternative to bone marrow transplantation. (CSA Rep. 2, A-03; Modified: CSAPH Rep. 1, A-13; Reaffirmed in lieu of: Res. 002, I-16)

9.6.2 Gifts to Physicians from Industry
Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties. Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.
To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:
(a) Decline cash gifts in any amount from an entity that has a direct interest in physicians’ treatment recommendations.
(b) Decline any gifts for which reciprocity is expected or implied.
(c) Accept an in-kind gift for the physician’s practice only when the gift:
(i) will directly benefit patients, including patient education; and
(ii) is of minimal value.
(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students’, residents’, and fellows’ participation in professional meetings, including educational meetings, provided:
(i) the program identifies recipients based on independent institutional criteria; and
(ii) funds are distributed to recipients without specific attribution to sponsors.

Early Detection and Prevention of Skin Cancer H-55.972
Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients’ skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining
areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. (CCB/CLRPD Rep. 3, A-14)

Safe Disposal of Used Syringes, Needles and Other Sharps in the Community H-95.942
1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public.
2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal.
3. Our AMA continues to support the mission of the Coalition for Safe Community Needle Disposal. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 914, I-16)

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945
Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term. (CCB/CLRPD Rep. 3, A-14)

Establishing Tax Benefits for Living Organ Donors: The MSS formally establishes support for the following HOD policy:

Methods to Increase the US Organ Donor Pool H-370.959
In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues. (BOT Rep. 13, A-15; Reaffirmed in lieu of: Res. 002, I-16; Modified: CSAPH Rep. 02, I-17)

Addressing the Rise of Medical School Tuition: The MSS formally establishes support for the following HOD policy:

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
1. It is AMA policy that:
A. Since quality medical education directly benefits the American people, there should be public 
support for medical schools and graduate medical education programs and for the teaching 
institutions in which medical education occurs. Such support is required to ensure that there is a 
continuing supply of well-educated, competent physicians to care for the American public.
B. Planning to modify health system organization or financing should include consideration of the 
effects on medical education, with the goal of preserving and enhancing the quality of medical 
education and the quality of and access to care in teaching institutions are preserved.
C. Adequate and stable funding should be available to support quality undergraduate and graduate 
medical education programs. Our AMA and the federation should advocate for medical education 
funding.
D. Diversified sources of funding should be available to support medical schools' multiple 
missions, including education, research, and clinical service. Reliance on any particular revenue 
source should not jeopardize the balance among a medical school's missions.
E. All payers for health care, including the federal government, the states, and private payers, 
benefit from graduate medical education and should directly contribute to its funding.
F. Full Medicare direct medical education funding should be available for the number of years 
required for initial board certification. For combined residency programs, funding should be 
available for the longest of the individual programs plus one additional year. There should be 
opportunities to extend the period of full funding for specialties or subspecialties where there is a 
documented need, including a physician shortage.
G. Medical schools should develop systems to explicitly document and reimburse faculty 
teaching activity, so as to facilitate faculty participation in medical student and resident physician 
education and training.
H. Funding for graduate medical education should support the training of resident physicians in 
both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must 
take into account the resources, including volunteer faculty time and practice expenses, needed 
for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME 
should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and 
residency training positions, preferably in or adjacent to physician shortage/underserved areas and 
in undersupplied specialties.
2. Our AMA endorses the following principles of social accountability and promotes their 
application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care 
and specialty practice workforce distribution; (c) Geographic workforce distribution; and 
(d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and 
fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME 
funding and therefore, regardless of the method or source of payment for GME or the number of 
funding streams, institutions should publicly report the aggregate value of GME payments 
received as well as what these payments are used for, including: (a) Resident salary and benefits; 
(b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching 
staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor 
indirectly reduce funding levels for any other specialty. (CME Rep. 7, A-05; Reaffirmation I-06; 
10; Reaffirmation 11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 
05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16)
Increasing Access to Healthcare Insurance for Refugee Populations: The MSS formally establishes support for the following HOD policy:

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees. (Res. 006, A-17)

Evaluation on Researching Non-Judicial Enforcement of Medicaid Rate Challenges Under 42 U.S.C Section 1396A(A) (30)(a) in Wake of Armstrong V. Exceptional Child Center, Inc.: The MSS formally establishes support for the following HOD policy:

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits. (CMS Rep. 02, A-16; Reaffirmation: A-17)
Reducing Maternal Tobacco Use During Pregnancy: The MSS formally establishes support for the following HOD policy:

Preconception Care H-425.976
1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:
   (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
   (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
   (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
   (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
   (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
   (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
   (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
   (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
   (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
   (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.
2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record. (Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17) (MSS Res 24, I-18)

Encouraging Development of Physician Liability Guidelines in Telemedicine: The MSS formally establishes support for the following HOD policy:

Telemedicine H-480.968
The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in

(MSS Res 26, I-18)

**Advocate to End Child Marriage in the United States:** The MSS formally establishes support for the following HOD policy:


(MSS Res 31, I-18)

**End Punitive Measures for Pregnant Women Who Use Drugs:** The MSS formally establishes support for the following HOD policy:

Drug Testing H-95.985 Our AMA believes that physicians should be familiar with the strengths and limitations of drug testing techniques and programs:

1. Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.

2. Results from drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself, provide indication or proof of child abuse, or neglect or proof of inadequate parenting.

3. Before implementing a drug testing program, physicians should: (a) understand the objectives and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. Physicians also should be satisfied that the selection of drugs (analytes) and subjects to be tested as well as the screening and confirmatory techniques that are used meet the stated objectives.

4. Since physicians often are called upon to interpret results, they should be familiar with the disposition characteristics of the drugs to be tested before interpreting any results. If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts such as a certified medical review officer should be pursued. (CSA Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 01, I-16)
Provision of Longitudinal Medical Care to Babies, Mothers, and Caregivers Impacted by Substance Use and Exposure: The MSS formally establishes support for the following HOD policy:

Addiction and Unhealthy Substance Use H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09)

Addressing Disparities Related to Breast Cancer Differences between African American Women and Other Women: The MSS formally establishes support for the following HOD policy:

Cancer and Health Care Disparities Among Minority Women D-55.997
Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment. (Res. 509, A-08; Modified: CSAPH Rep. 01, A-18)

Amendment to H-170.967 and D-60.994 for Inclusion of Comprehensive Sexual Health Education for Incarcerated Juveniles: The MSS formally establishes support for the following HOD policy:
Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system. (CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16)

Implementing Elective Rotations and Increasing Exposure to Prisons into the Medical Education Curriculum: The MSS formally establishes support for the following HOD policy:

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.

2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.

3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.

4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.

5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.

6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties. (CME Rep. 11, A-09; Reaffirmed: CME Rep. 03, I-18)
Increasing Education regarding Transition Planning for Children with Chronic Health Conditions, not Limited to Those with Developmental Disabilities: The MSS formally establishes support for the following HOD policy:

Children and Youth with Disabilities H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations. (CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)

(MSS Res 52, I-18)

Addressing Medical Data Vulnerabilities in Bluetooth and Other Short-Range Wireless Technologies:
The MSS formally establishes support for the following HOD policies:

Medical Device Safety and Physician Responsibility H-480.972
The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use. (Res. 507, I-95; Res. 509, A-96; Appended Res. 504, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Use of Wireless Radio-Frequency Devices in Hospitals H-215.972
Our AMA encourages: (1) collaborative efforts of the Food and Drug Administration, American Hospital Association, American Society for Healthcare Engineering, Association for the Advancement of Medical Instrumentation, Emergency Care Research Institute, and other appropriate organizations to develop consistent guidelines for the use of wireless radio-frequency transmitters (e.g., cellular telephones, two-way radios) in hospitals and standards for medical equipment and device manufacturers to ensure electromagnetic compatibility between radio-frequency transmitters and medical devices; and that our AMA work with these organizations to increase awareness among physicians and patients about electromagnetic compatibility and electromagnetic interference in hospital environments; (2) hospital administrators to work with their clinical/biomedical engineering staff, safety committees, and other appropriate personnel to adopt and implement informed policies and
procedures for (a) managing the use of wireless radio-frequency sources in the hospital, particularly in critical patient care areas; (b) educating staff, patients, and visitors about risks of electromagnetic interference (EMI); (c) reporting actual or suspected EMI problems; and (d) testing medical devices for susceptibility to EMI when electromagnetic compatibility information is lacking; (3) medical device and electronic product manufacturers to design and test their products in conformance with current electromagnetic immunity standards and inform users about possible symptoms of electromagnetic interference (EMI). If a possibility of EMI problems affecting medical devices exists, steps should be taken to ensure that all sources of electromagnetic energy are kept at sufficient distance; and (4) physicians to become knowledgeable about electromagnetic compatibility and electromagnetic interference (EMI), recognize EMI as a potential problem in hospital environments, and report suspected EMI problems to the Food and Drug Administration MedWatch program or appropriate hospital personnel. (CSA Rep. 4, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

(MSS Res 58, I-18)

Enhancing Education and Reducing Advertising of Alcoholic Beverages: The MSS formally establishes support for the following HOD policy:

Alcohol and Youth D-170.998
Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. (Res. 415, I-01; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18)

(MSS Res 60, I-18)

Protect People Who Use Drugs from Prosecution in the Event of Overdose: The MSS formally establishes support for the following HOD policy:

911 Good Samaritan Laws D-95.977
Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level. (Res. 225, A-14)

(MSS Res 63, I-18)

Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication: The MSS formally establishes support for the following HOD policies:

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.


EHR Interoperability D-478.972 Our AMA:
(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
(4) will continue efforts to promote interoperability of EHRs and clinical registries;
(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18)

(MSS Committee on Health Information Technology Report A, I-18)

Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized Technologies: The MSS formally establishes support for the following HOD policy:

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be
applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.


(MSS Committee on Health and Information Technology and Committee on Economics and Quality in Medicine Joint Report A, I-18)

Encouraging Mental Health First Aid in the Community: The MSS formally establishes support for the following HOD policies:

Mental Health Crisis Interventions H-345.972

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports 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; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports 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. (Res. 923, I-15; Appended: Res. 220, I-18)

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine, and primary care training programs’ clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

4. Our AMA recognizes the impact of violence and social determinants on women’s mental health. (Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19)

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers, and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16)

(MSS Res 12, A-19)

Integrating Immigrant Rights Training into Residency Education: The MSS formally establishes support for the following HOD policy:

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities
to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities. (Res. 232, I-17)

(MSS Res 14, A-19)

Emergency Department Observation Units (EDOUs): A Step Toward Reducing Healthcare Costs: The MSS formally establishes support for the following HOD policy:

Emergency Department Boarding and Crowding H-130.940 Our AMA:
1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and
6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement. (CMS Rep. 3, A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: BOT Rep. 16, A-19)

(MSS Res 15, A-19)

Reducing Unnecessary Postoperative Labs: The MSS formally establishes support for the following HOD policies:

Comparative Effectiveness Research D-460.973
Our AMA will solicit from our members and others articles or postings about current clinical topics where comparative effectiveness research should be conducted and will periodically invite AMA members to recommend topics where the need for comparative effectiveness research is most pressing, and the results will be forwarded to the Patient-Centered Outcomes Research Institute (PCORI) once it is established, or to another relevant federal agency. (Res. 221, A-11)

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians’ professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
   a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
   b. is transparent;
   c. conforms to leading standards for reproducibility;
   d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
   e. safeguards patients’ and other individuals’ privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (BOT Rep. 41, A-18)

(MSS Res 22, A-19)

Advocate for a Global Carbon Pricing System: The MSS formally establishes support for the following HOD policy:

   Global Climate Change - The "Greenhouse Effect" H-135.977
   Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
   (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
   (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
   (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
   (5) encourages humanitarian measures to limit the burgeoning increase in world population.
   (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

(MSS Res 25, A-19)

Liver Transplant Guidelines Regarding Patients with History of Psychiatric Disorders: The MSS formally establishes support for the following HOD policies:

   Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982
   Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized
according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.


Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. (Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18)

(MSS Res 27, A-19)

Increased Coverage for HPV Vaccination: The MSS formally establishes support for the following HOD policies:

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction
and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. (Res. 503, A-07; Appended: Res. 6, A-12)

Insurance Coverage for HPV Vaccine D-440.955 Our AMA:
(1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations. (Res. 818, I-06; Reaffirmed: CMS Rep. 01, A-16)

(MSS Res 32, A-19)

Curtailing Greenhouse Gas Emissions to Net Zero in the Health Sector: The MSS formally establishes support for the following HOD policies:

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. (Res. 924, I-16)

Global Climate Change and Human Health H-135.938 Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA’s Center for Public Health Preparedness and Disaster Response assist in this effort.

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of ’green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18)

(MSS Res 33, A-19)

Transgender and Intersex Care Training for School Health Professionals: The MSS formally establishes support for the following HOD policies:

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner
violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18)

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878 Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18)

(MSS Resolution 40, A-19)