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

| **Cmte\*** | **Item** | **Sponsor†** | **Title** | **Recommendations or Resolves** |
| --- | --- | --- | --- | --- |
| .CON | BOT 02 | n/a | New Specialty Organizations Representation in the House of Delegates | Therefore, the Board of Trustees recommend that the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle Medicine, American Venous Forum, Association of Academic Physiatrists, and Society for Pediatric Dermatology be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action) |
| .CON | CCB 01 | n/a | AMA Bylaws—Nomination of Officers and Council Members | The Council on Constitution and Bylaws recommends that the following amendments to our AMA Bylaws be adopted, that Policy G-610.989 be rescinded, and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.  **3 Officers**   3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place and may be announced by the Board of Trustees.  **6 Councils**    **6.8 Election – Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health**    **6.8.1 Nomination and Election.** Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair Nominations shall be made by the chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the Opening session of the meeting at which elections take place. Nominations and may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.  (Modify Bylaws) |
| .CON | CCB 02 (1of3) | n/a | AMA Bylaws—Run-Off and Tie Ballots | The Council on Constitution and Bylaws recommends that the following amendments to our AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.  3 Officers  3.4 Elections.  3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.  3.4.2.1 At-Large Trustees.  3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of Trustees to be elected.  ~~3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.~~ 3.4.2.1.2 ~~3~~ Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the larger number of votes within the number of Trustees to be elected or remaining to be elected. ~~and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees.~~ This procedure shall be repeated until all vacancies have been filled. |
| .CON | CCB 02 (2of3) | n/a | AMA Bylaws—Run-Off and Tie Ballots | 3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~  This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.   6 Councils  6.8 Election – Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health  6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions result in fewer than two nominees, the nominees with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.   6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of members to be elected. |
| .CON | CCB 02 (3of3) | n/a |  | ~~6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.~~  6.8.1.4 Subsequent Ballots. If all vacancies are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two remaining nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of council members to be elected or remaining to be elected. ~~and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee.~~ This procedure shall be repeated until all vacancies have been filled. |
| .CON | CCB 03 | n/a | AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997) | The Council on Constitution and Bylaws recommends that the following recommendations be adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed.   1) That our AMA Bylaws be amended by insertion to add the following provisions. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting:  3. Officers  3.6 Vacancies.  3.6.4 Absences. If an officer misses 6 consecutive regular meetings of the Board, this matter shall be reported to the House of Delegates by the Board of Trustees and the office shall be considered vacant. The vacancy shall be filled as provided in Bylaw 3.6.1 or Bylaw 3.6.3.  3.6.5 Removal for Cause. Any officer may be removed for cause in accordance with procedures established by the House of Delegates.  6. Councils  6.0.1.4 Removal. A Council member may be removed for cause in accordance with procedures approved by the House of Delegates.  7. Sections  7.0.3.4 Removal. A Governing Council member may be removed for cause in accordance with procedures approved by the House of Delegates.  (Modify Bylaws)  2) That the Councils on Constitution and Bylaws, Long Range Planning and Development and the Ethical and Judicial Affairs and the House develop the procedures to remove a trustee, council member or governing council member for cause. (Directive to Take Action)   3) That the Election Committee address the need for policy to remove candidates who are found to violate AMA policy G-610.090, AMA Election Rules and Guiding Principles. (Directive to Take Action) |
| .CON | CCB 04 | n/a | AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.) | The Council on Constitution and Bylaws recommends that the following recommendations be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting:  1) That our AMA Bylaws be amended by insertion and deletion as follows:  2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on ~~written or electronic~~ request ~~by~~ of one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall notify ~~mail a notice to the last known address of~~ each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.  2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation ~~in writing~~, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.  5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, ~~mail~~, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee’s contact information then appearing on the records of the AMA.  5.2.4.1 Waiver of Notice. ~~Notice of any meeting need not be given if waived in writing before, during or after such meeting.~~ Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting.  12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and provided it to ~~submitted it in writing~~ to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered. (Modify Bylaws) |
| .CON | CEJA 01 | n/a | Short-Term Global Health Clinical Encounters | In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted, and the remainder of this report be filed:  Short-term global health clinical encounters, which send physicians and physicians in training from wealthier communities to provide care in under-resourced settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such encounters also provide training and educational opportunities, they may offer benefit both to the host communities and the medical professionals and trainees who volunteer their time and clinical skills.   Short-term global health clinical encounters typically take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term global health clinical encounters requires diligent preparation on the part of participants and sponsors in collaboration with host communities.  Physicians and trainees who are involved with short-term global health clinical encounters should ensure that the trips with which they are associated:  (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the visiting medical team or the sponsoring organization.  (b) Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting participants, but also possible adverse effects the presence of participants could have for beneficial local practices and local practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.   (c) Provide resources that help them become broadly knowledgeable about the communities in which they will work and to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the visiting medical team are expected to uphold the ethics standards of their profession and participants should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect that will have on the patient, the medical team, and the project overall, in keeping with ethics guidance on the exercise of conscience. Participants should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.  (d) Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer guidance regarding the evaluation process of the experience, in an effort to enhance and improve the outcomes of future encounters.  Sponsors of short-term global health clinical encounters should:  (e) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and participants’ personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.  (f) Proactively define appropriate roles and permissible range of practice for members of the visiting medical team, so that they can provide safe, high-quality care in the host community. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable in their ordinary clinical practice, even if the host community’s standards are more flexible or less rigorously enforced.   (g) Ensure appropriate supervision of trainees, consistent with their training in their home communities, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in under-resourced settings.   (h) Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor’s country. (New HOD Policy) (New HOD/CEJA Policy) |
| .CON | CEJA 02 | n/a | Research Handling of De-Identified Patient Data (D-315.969) | In light of the challenges considered with regard to constructing a framework for holding stakeholders accountable within digital health information ecosystems, the Council on Ethical and Judicial Affairs recommends:  1. That the following be adopted: Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health.  When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession’s responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.  As individuals or members of health care institutions, physicians should:  (a) Follow existing and emerging regulatory safety measures to protect patient privacy;  (b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets;  (c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with current federal and state legal standards.   Health care entities, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:  (d) The high value that health care institutions place on protecting patient data;  (e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist;  (f) How patient data may be used;  (g) The importance of de-identified aggregated data for improving the care of future patients.  Health care entities managing de-identified datasets, as health data stewards, should:  (h) Ensure appropriate data collection methods and practices that meet industry standards to support the creation of high-quality datasets;  (i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing Agreements for the use of de-identified datasets that may be shared, sold, or resold;  (j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and potential resale of clinically-derived datasets;  (k) Take appropriate cyber security measures to seek to ensure the highest level of protection is provided to patients and patient data;  (l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients;  (m) Advocate that health- and non-health entities using any health data adopt the strongest protections and seek to uphold the ethical values of the medical profession.  There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients’ express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and   2. That Opinion 2.1.1, “Informed Consent”; Opinion 3.1.1, “Privacy in Health Care”; Opinion 3.2.4, “Access to Medical Records by Data Collection Companies”; and Opinion 3.3.2, “Confidentiality and Electronic Medical Records” be amended by addition as follows: a. Opinion 2.1.1, Informed Consent Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients’ health data and how data may be used.  The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:  (a) Assess the patient’s ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.  (b) Present relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information. The physician should include information about:  (i) the diagnosis (when known);  (ii) the nature and purpose of recommended interventions;  (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.  (c) Document the informed consent conversation and the patient’s (or surrogate’s) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.  In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient’s surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)  b. Opinion 3.1.1, Privacy in Health Care Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust. Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).  Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:  (a) Minimize intrusion on privacy when the patient’s privacy must be balanced against other factors.  (b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.  (c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.  (d) Be transparent with any inquiry about existing privacy safeguards for patient data but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)  c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies Information contained in patients’ medical records about physicians’ prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians’ treatment recommendations, such as pharmaceutical or medical device companies.  Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.  Physicians who propose to permit third-party access to specific patient information for commercial purposes should:  (a) Only provide data that has been de-identified.  (b) Fully inform each patient whose record would be involved (or the patient’s authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.  Physicians who propose to permit third parties to access the patient’s full medical record should:  (c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient’s medical record.   (d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.  (e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.  Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to establish that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)  d. Opinion 3.3.2, Confidentiality and Electronic Medical Records Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.  Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:   (a) Choose a system that conforms to acceptable industry practices and standards with respect to:  (i) restriction of data entry and access to authorized personnel;  (ii) capacity to routinely monitor/audit access to records;  (iii) measures to ensure data security and integrity; and  (iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.  (b) Describe how the confidentiality and integrity of information is protected if the patient requests.  (c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and  3. That the remainder of this report be filed. |
| .CON | CEJA 03 | n/a | Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices | In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, “Contracts to Deliver Health Care Services,” be amended by addition and deletion as follows and the remainder of this report be filed:   Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.  Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians’ ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians’ freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.  As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients’ interests at risk and to interfere with physician autonomy.  When ~~contracting~~ partnering with entities, or having a representative do so on their behalf, to provide health care services, physicians should:  (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:  (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians’ treatment recommendations or direct what care patients receive, in keeping with ethics guidance;  (ii) does not compromise the physician’s own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;  (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;  (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;  (v) is transparent and permits disclosure to patients.  (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing.   (b) Negotiate modification or removal of any terms that unduly compromise physicians’ ability to uphold ethical or professional standards.  When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians must:  (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.  (d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.   (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues. (Modify HOD/CEJA Policy) |
| .CON | CEJA 04 | n/a | Physicians’ Use of Social Media for Product Promotion and Compensation | In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that: Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as follows and the remainder of this report be filed:  Social media—internet-enabled communication platforms—enable individual medical students and physicians to have both a personal and a professional presence online. Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to widely disseminate public health messages and other health communications. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.  Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:  (a) When publishing any content, consider that even personal social media posts have the potential to damage their professional reputation or even impugn the integrity of the profession.  (b) Respect professional standards of patient privacy and confidentiality and refrain from publishing patient information online without appropriate consent.   (c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with their patients through social media, just as they would in any other context.  (d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.  (e) Publicly disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.  (f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate based on professional medical judgment. (Modify HOD/CEJA Policy) |
| .CON | CEJA 05 | n/a | CEJA’s Sunset Review of 2014 House Policies | The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| .CON | Res. 001 | Integrated Physician Practice Section | Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout | RESOLVED, that our American Medical Association monitor and report on the research regarding technology, measures, and effective use of personal and biological data which supports professional workforce wellbeing and mitigates burnout (Directive to Take Action);   RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of personal and biological data for the professional workforce (Directive to Take Action) |
| .CON | Res. 002 | Medical Student Section | Removal of the Interim Meeting Resolution Committee | RESOLVED, that our American Medical Association remove the Resolution Committee from Interim Meetings by amending AMA Bylaw B-2.13.3, “Resolution Committee,” by deletion as follows:  **~~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. (Modify Bylaws); and be it further~~  RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1, “Business of Interim Meeting,” by deletion as follows:  **~~2.12.1.1 Business of Interim Meeting~~**~~The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.~~ (Modify Bylaws) |
| .CON | Res. 003 | Medical Student Section | Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity | RESOLVED, that our American Medical Association amend AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation. (Modify Bylaws) |
| .CON | Res. 004 | Epps, Thomas W. MD | The Rights of Newborns that Survive Abortion | RESOLVED, that our American Medical Association amend the current policy right for an abortion to “a woman’s right to abortion as only the right to terminate the pregnancy" (Modify Current HOD Policy)  RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical care. (New HOD Policy) |
| .CON | Res. 005 | Mississippi | AMA Executive Vice President | RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties and Privileges Code B-5.3.6.4 as follows:  ~~No individual who has served as an AMA officer or trustee shall be selected or serve as Executive Vice President until three years following completion of the term of the AMA office.”~~(Modify Bylaws) |
| .CON | Res. 006 | Missouri | Treatment of Family Members | RESOLVED, that our American Medical Association asks CEJA to review and revise the current code of ethics as it relates to treating family members (Directive to Take Action)  RESOLVED, that our AMA ask CEJA to report back to the HOD on this issue at the next interim meeting I-24 |
| .CON | Res. 007 | American Association of Public Health Physicians | AMA Supports a Strategy for Eliminating Nuclear Weapons | RESOLVED, that our American Medical Association calls for the United States to renounce the option to be the first country to use nuclear weapons (“first use”) during a conflict (Directive to Take Action)  RESOLVED, that our AMA supports a process whereby multiple individuals, rather than solely the President, are required to approve a nuclear attack, while still allowing a swift response when needed (New HOD Policy)   RESOLVED, that our AMA calls on the US government to cancel plans to rebuild its entire nuclear arsenal and instead to reassess its true strategic needs for the types and numbers of nuclear weapons and delivery systems. (Directive to Take Action) |
| .CON | Res. 008 | McAneny, Barbara L. MD, | Consolidated Health Care Market | RESOLVED, that our American Medical Association investigate the possibility of filing a class action lawsuit against Optum, United Health Group and Change Health to recoup the damages from the disruption caused by the breach, and to distribute the unfair enrichment profits made by Optum et al to the practices whose retained payments allowed them to generate interest and investment profits (Directive to Take Action)  RESOLVED, that our AMA investigate the acquisition of practices by Optum in the aftermath of the breach and determine if the independence of those practices can be resurrected, and if not, if damages are due to the physician owners of the acquired practices. (Directive to Take Action) |
| .CON | Res. 014 | New England | The Preservation of the Primary Care Relationship | RESOLVED, that our American Medical Association opposes health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care (New HOD Policy)  RESOLVED that our AMA requests the Council on Ethical and Judicial Affairs review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists (Directive to Take Action)  RESOLVED, that our AMA advocates for policies that promote patient choice, ensure continuity of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives. (Directive to Take Action) |
| .CON | Res. 015 | New England | Health and Racial Equity in Medical Education to Combat Workforce Disparities | RESOLVED, that our American Medical Association further study and track the prevalence of attending physicians’ and trainees’ dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities (Directive to Take Action)  RESOLVED, that our AMA engage stakeholders to study and report back how to effectively support underrepresented groups in medicine to level the playing field for those most affected by bias and historical harms (Directive to Take Action)  RESOLVED, that our AMA work with stakeholders to make recommendations on a review and appeals process that will enable physicians and trainees to receive a fair and equitable due process in defense of alleged shortcomings. (Directive to Take Action) |
| .CON | Res. 016 | New York | Guiding Principles for the Healthcare of Migrants | RESOLVED, that our American Medical Association advocate for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the “Colombo Statement” (Directive to Take Action);  RESOLVED, that our AMA recognizes that migration status is a social determinant of health (New HOD Policy); RESOLVED, that our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration (New HOD Policy);  RESOLVED, that our AMA recognizes that the enhancement of migrants’ health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families (New HOD Policy);   RESOLVED, that our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard (New HOD Policy)   RESOLVED, that our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization’s 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by 1. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.  2. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.  3. Ensuring that the social determinants of migrants’ health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.  4. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.  5. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems. (New HOD Policy) |
| .CON | Res. 017 | New York | Addressing the Historical Injustices of Anatomical Specimen Use | RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments; as required by laws such as the Native American Graves and Repatriation Act (Directive to Take Action);  RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of Black and Brown people and other minority groups, and return remains and skeletal collections to living family members, or, if none exist, then respectful burial of anatomical specimens or remains (Directive to Take Action);  RESOLVED, that Our AMA seek legislation or regulation that requires the return of anatomic specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups (Directive to Take Action);  RESOLVED, that Our AMA support the creation of a national anatomical specimen database that includes registry demographics (New HOD Policy);  RESOLVED, that our AMA study and develop recommendations regarding regulations for ethical body donations including, but not limited to guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue (Directive to Take Action);  RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors should be amended as follows: Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.(b) Has been developed in consultation with the population among whom it is to be carried out.(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.Unless there are data that suggest a positive effect on donation, n Neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.(Modify Current HOD Policy) |
| .CON | Res. 018 | New York | Opposing Violence, Terrorism, Discrimination, and Hate Speech | RESOLVED, that our American Medical Association strongly condemns all acts of violence, terrorism, discrimination, and hate speech against any group or individual, regardless of race, ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other factor (New HOD Policy); RESOLVED, that our AMA affirms its commitment to promoting dialogue, empathy, and mutual respect among diverse communities, recognizing the importance of fostering understanding and reconciliation (New HOD Policy);  RESOLVED, that our AMA recognizes the importance of commemorating and honoring the victims of tragedies throughout human history, in a manner that respects the dignity and sensitivities of all affected communities (New HOD Policy);  RESOLVED, that our AMA encourages initiatives that promote education, awareness, and solidarity to prevent future acts of violence and promote social cohesion (New HOD Policy);  RESOLVED, that our AMA acknowledges the diverse perspectives and experiences within its membership and commits to facilitating constructive dialogue and engagement on sensitive and polarizing issues (New HOD Policy);  RESOLVED, that our AMA calls for continued collaboration and partnership with organizations representing diverse communities. (Directive to Take Action) |
| .CON | Res. 019 | Minority Affairs Section | Supporting the Health of Our Democracy | RESOLVED, that our American Medical Association support policies that ensure safe and equitable access to voting and opposes the institutional barriers to both the process of voter registration and the act of casting a vote (New HOD Policy)  RESOLVED, that our AMA encourage physicians and medical trainees to vote, oppose barriers to their participation in the electoral process, and support their and other healthcare workers’ engagement in nonpartisan voter registration efforts in healthcare settings, including emergency absentee ballot procedures for qualifying patients, visitors, and healthcare workers (New HOD Policy)  RESOLVED, that our AMA support the use of independent, nonpartisan commissions to draw districts for both federal and state elections. (New HOD Policy) |
| .CON | Res. 020 | Minority Affairs Section | Voter Protections During and After Incarceration | RESOLVED, that our AMA research the impact of disproportionate policing in and incarceration of minoritized communities on voter participation and health outcomes (Directive to Take Action)  RESOLVED, that our AMA develop educational materials and programming to educate medical trainees and physicians on the impact of incarceration on voting and health outcomes. (Directive to Take Action) |
| .CON | Res. 021 | Minority Affairs Section | Opposition to Capital Punishment | RESOLVED, that our American Medical Association amend H-140.896, “Moratorium on Capital Punishment,” by addition and deletion as follows:  **Opposition to ~~Moratorium on~~ Capital Punishment H-140.896** Our AMA: (1) opposes all forms of ~~does not take a position~~ on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process. (Modify Current HOD Policy) |
| .CON | Res. 022 | Minority Affairs Section | Health and Racial Equity in Medical Education to Combat Workforce Disparities | RESOLVED, that our American Medical Association further study and track the prevalence of attending physicians’ and trainees’ dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities (Directive to Take Action)  RESOLVED, that our American Medical Association further study and track the prevalence of attending physicians’ and trainees’ dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities (Directive to Take Action)  RESOLVED, that our AMA engage stakeholders to study and report back how to effectively support underrepresented groups in medicine to level the playing field for those most affected by bias and historical harms (Directive to Take Action)  RESOLVED, that our AMA work with stakeholders to make recommendations on a review and appeals process that will enable physicians and trainees to receive a fair and equitable due process in defense of alleged shortcomings. (Directive to Take Action) |
| .CON | Res. 009 | Resident and Fellow Section | Updating Language Regarding Families and Pregnant Persons | RESOLVED, that our American Medical Association review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures. (Directive to Take Action) |
| .CON | Res. 012 | Mississippi | Ethical Pricing Procedures that Protect Insured Patients | RESOLVED, that our American Medical Association advocate for policies that limit the cost of a medication to an insured patient with medication coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer’s free discount card (such as GoodRx) (Directive to Take Action)  RESOLVED, that our AMA write a letter to lawmakers and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients. (Directive to Take Action) |
| .CON | Res. 013 | American College of Obstetricians and Gynecologists | Ethical Impetus for Research in Pregnant and Lactating Individuals | RESOLVED, that our American Medical Association Council on Ethical and Judicial Affairs update its ethical guidance on research in pregnant and lactating individuals. (Directive to Take Action) |
| A | CMS 02 | n/a | Improving Affordability of Employment-Based Health Coverage | The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed.  1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition and deletion to read: 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 the ~~level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage~~ maximum percentage of income they would be required to pay towards premiums after accounting for subsidies ~~in~~ for an Affordable Care Act (ACA) marketplaces benchmark plan. (Modify HOD Policy)  2. That our AMA amend Policy H-165.843 by addition and deletion to read: Our AMA encourages employers to: a) promote greater individual choice and ownership of plans; b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria;  c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance; ~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan’s cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs; ~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices; ~~d~~f) support increased fairness and uniformity in the health insurance market; and ~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)  3. That our AMA support efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards, like those required of nongroup marketplace plans. (New HOD Policy)  4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance. (Reaffirm HOD Policy)   5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it, and other principles related to health insurance. (Reaffirm HOD Policy) |
| A | CMS 03 | n/a | Review of Payment Options for Traditional Healing Services | The Council on Medical Service recommends that the following be adopted in lieu of Resolution 106-A-23, and the remainder of the report be filed:  1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and deletion, and modify the title by addition, as follows: Improving Health Care of American Indians and Alaska Natives H-350.976 (1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives. (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life. (4) American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives. (6) Our AMA support monitoring of Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care. (7) Our AMA support consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs. (~~6~~8) Strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (~~7~~9) 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~~10) 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~~11) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside. (~~10~~12) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native 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 and Alaska Natives. (~~11~~13) 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 Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (Modify HOD Policy)  2. That our AMA reaffirm Policy D-350.996, which states that the AMA will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts. (Reaffirm HOD Policy)  3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy H-350.949, which encourages state Medicaid agencies to follow the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group’s recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-350.977, which supports expanding the American Indian role in their own health care and increased involvement of private practitioners and facilities in American Indian health care through such mechanisms as agreements with Tribal leaders or Indian Health Service contracts, as well as normal private practice relationships. (Reaffirm HOD Policy) |
| A | CMS 07 | n/a | Ensuring Privacy in Retail Health Care Settings | The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:  1. That our American Medical Association (AMA) will: (a) support regulatory guidance to establish a privacy wall between the health business and non-health business of retail health care companies to eliminate sharing of protected health information, re-identifiable patient data, or data that could be reasonably be used to re-identify a patient when combined with other data for uses not directly related to patients’ medical care; (b) support the prohibition of Terms of Use that require data sharing for uses not directly related to patients’ medical care in order to receive care, while still allowing data sharing where required by law (e.g., infectious disease reporting); (c) support the separation of consents required to receive care from any consents to share data for non-medical care reasons, with clear indication that patients do not need to sign the data-sharing agreements in order to receive care; (d) support the prohibition of “clickwrap” contracts for use of a health care service without affirmative patient consent to data sharing; (e) support the requirement that retail health care companies must use an active opt-in selection for obtaining meaningful consent for data use and disclosure, otherwise the default should be that the patient does not consent to disclosure; (f) support the requirement that retail health care companies clearly indicate how patients can withdraw consent and request deletion of data retained by the non-health care providing units, which should be by a means no more onerous than providing the initial consent. (New HOD Policy)  2. That our AMA reaffirm Policy D-315.968, which advocates for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles. (Reaffirm HOD Policy)  3. That our AMA reaffirm Policy H-315.962, which supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such data. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy H-480.940, which promotes development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients’ privacy interests and preserves the security and integrity of personal information. (Reaffirm HOD Policy)  5. Rescind Policy H-315.960, as having been completed with this report. (Rescind HOD Policy) |
| A | CMS 08 | n/a | Sustainable Payment for Community Practices | The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:  1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid. (New HOD Policy)  2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows: Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990 Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a ~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, the value of the care provided, and includes an inflation-based update; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee s~~Schedule. (Modify Current HOD Policy)  3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows: Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976 1. It is the policy of our AMA that prior to or concomitant with states’ expansion of ~~State~~ Children’s Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds. 2. Our AMA affirms its commitment to advocating for ~~reasonable S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, ~~reimbursement for its medical providers, defined as at minimum~~ and is no less than 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)  4. That our AMA amend Policy H-385.921 by addition and deletion as follows: Health Care Access for Medicaid Patients H-385.921 It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice, the value of the care provided, and include inflation-based updates, and is no less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable. (Modify Current HOD Policy)  5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)  6. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)  7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians. (Reaffirm HOD Policy)  8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy) |
| A | Res. 101 | Medical Student Section | Infertility Coverage | RESOLVED, that our American Medical Association 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~~ supports federal protections 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 work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy)  RESOLVED, that our AMA study the feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility (Directive to Take Action)  RESOLVED, that our AMA support the review of services defined to be experimental or excluded for payment by the Indian Health Service and for the appropriate bodies to make evidence-based recommendations for updated health services coverage. (New HOD Policy) |
| A | Res. 102 | Medical Student Section | Medicaid & CHIP Benefit Improvements | RESOLVED, that our American Medical Association amend H-185.929 Hearing Aid Coverage by addition as follows;  Hearing Aid Coverage H-185.929 1. Our American Medical Association 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 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. 8. Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings. 9. Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. 10. Our AMA advocates that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid and CHIP programs and any new public payers. (Modify Current HOD Policy) RESOLVED, that our AMA advocate that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and by any new public payers (Directive to Take Action)  RESOLVED, that our AMA amend H-330.872, “Medicare Coverage for Dental Services” by addition and deletion as follows. Medicare 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, CHIP, and other public payer beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in the~~ Medicare, Medicaid, CHIP, and other public payer beneficiaries ~~population~~, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease ~~in the~~ among Medicare, Medicaid, CHIP, and other public payer beneficiaries ~~population~~, and the impact of expanded dental coverage on health care costs and utilization. (Modify Current HOD Policy) |
| A | Res. 103 | Oklahoma | Medicare Advantage Plans | RESOLVED, that our American Medical Association urge the United States Congress and Center for Medicare and Medicaid Services to take steps to end the upcoding for Medicare Advantage plans that results in high subsidies which are unfair to traditional Medicare and burdensome to the public treasury and many beneficiaries (New HOD Policy)  RESOLVED, that our AMA encourages Center for Medicare and Medicaid Services to improve the attractiveness of traditional Medicare so that the option remains robust and available giving beneficiaries greater traditional choices for this option and to seek better care for themselves. (New HOD Policy) |
| A | Res. 104 | Medical Student Section | Medicaid Estate Recovery Reform | RESOLVED, that our American Medical Association oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid. (New HOD Policy) |
| A | Res. 105 | Medical Student Section | Medigap Patient Protections | RESOLVED, that our American Medical Association support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans (New HOD Policy);   RESOLVED, that our AMA advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Actfor commercial insurance plans (Directive to Take Action);   RESOLVED, that our AMA support efforts to expand access to Medigap policies to all individuals who qualify for Medicare benefits (New HOD Policy);   RESOLVED, that our AMA supports efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries. (New HOD Policy) |
| A | Res. 106 | American Society for Gastrointestinal Endoscopy | Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum | RESOLVED, that our American Medical Association Policy H-185.960, “Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans” be amended by addition to read as follows: 1. Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. 2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients. 3. Our AMA will seek to eliminate cost-sharing in all health plans for “follow-on” colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests are found to be positive. 4. Our AMA will seek to classify follow-up, follow-on, or surveillance, colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances. (Modify Current HOD Policy) |
| A | Res. 107 | Mississippi | Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies | RESOLVED, that our American Medical Association advocate that government-owned health agencies such as Medicare and Medicaid be required to contract only with not-for-profit insurance companies or cooperatives (Directive to Take Action);   RESOLVED, that our AMA support that those not-for-profit insurance companies or cooperatives receiving public revenues must allocate profits to reserves, investments in improving the quality of care in the system, or returned in the form of lower premiums for patients or the health agency. (New HOD Policy) |
| A | Res. 108 | Mississippi | Requiring Payments for Physician Signatures | RESOLVED, that our American Medical Association advocate that insurance companies be required to pay a physician for any required physician signature and/or peer to peer review which is requested or required outside of a patient visit. (Directive to Take Action) |
| A | Res. 109 | Association for Clinical Oncology | Coverage for Dental Services Medically Necessary for Cancer Care | RESOLVED, that our American Medical Association supports that oral examination and dental services prior to and following the administration of radiation, chemotherapy, chimeric antigen receptor (CAR) T-cell therapy and high-dose bone-modifying agents for the treatment of cancer are part of medically necessary care (New HOD Policy)  RESOLVED, that our AMA will advocate that all insurers cover medically necessary oral examination and dental services prior to the administration of and resulting as a complication of radiation, chemotherapy and/or surgery for all cancer of the head and neck region. (Directive to Take Action) |
| A | Res. 110 | American Academy of Physical Medicine and Rehabilitation | Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses | RESOLVED, that our American Medical Association support coverage by all private and government insurance companies for pediatric footwear suitable for use with lower extremity orthoses and medically necessary shoe modifications. (New HOD Policy) |
| A | Res. 111 | Ohio | Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare | RESOLVED, that our American Medical Association pursue all necessary legislative and administrative measures to ensure that Medicare beneficiaries have the freedom to switch back to Traditional Medicare and obtain Medigap insurance under federal "guaranteed issue" protections. (Directive to Take Action) |
| A | Res. 112 | American Academy of Physical Medicine and Rehabilitation | Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses | RESOLVED, that our American Medical Association recognizes activity-specific adaptive sports and exercise equipment as assistive devices that are integral to the health maintenance of persons with disabilities in accordance with national exercise guidelines (New HOD Policy)  RESOLVED, that our AMA recognizes activity-specific adaptive sports and exercise equipment, such as activity-specific prostheses and orthoses, as medical devices that facilitate independence and community participation (New HOD Policy)  RESOLVED, that our AMA advocate for coverage by all private and public insurance plans for activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities in order to promote health maintenance and chronic disease prevention. (Directive to Take Action) |
| A | Res. 113 | New England | Support Prescription Medication Price Negotiation | RESOLVED, that our American Medical Association support pharmaceutical price negotiation for all prescription medications, both Medicare and private insurance (New HOD Policy);   RESOLVED, that our AMA advocate for any medication price that is raised by a pharmaceutical company more than the rate of inflation be immediately subject to price negotiation in the following year’s negotiation schedule (Directive to Take Action);   RESOLVED, that our AMA support extending the cap on annual out of pocket prescription drug spending in Medicare Part D plans to all insurance plans. (New HOD Policy) |
| A | Res. 114 | New York | Breast Cancer Screening/Clinical Breast Exam Coverage | RESOLVED, that our American Medical Association advocate for Medicare coverage of clinical breast exams for all female and at-risk male patients during the Medicare Annual Wellness Visit (AWV) and Subsequent Annual Wellness Visit (SAWV) appointments. (Directive to Take Action) |
| A | Res. 115 | New York | Payments by Medicare Secondary or Supplemental plans | RESOLVED, that our American Medical Association advocate for legislation that would mandate that all health plans cover Medicare secondary claims regardless of the provider participating in the secondary health plan (Directive to Take Action)  RESOLVED, that our AMA will report on the status of this resolution and policies H-390.839 and D-390.984 at the 2025 Annual Meeting. (Directive to Take Action) |
| B | BOT 09 | n/a | Council on Legislation Sunset Review of 2014 House Policies | The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| B | BOT 11 | n/a | Safe and Effective Overdose Reversal Medications in Educational Settings | The Board of Trustees recommends that the following be adopted, and that the remainder of the report be filed: 1. Existing American Medical Association (AMA) policy entitled, “Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications” (Policy H-95.932), be reaffirmed, and (Reaffirm HOD Policy) 2. The third resolve of Policy H-95.908, “Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings” be rescinded and that the policy be updated as noted. (Modify Current HOD Policy) 1. Our AMA will encourage states, communities, and educational settings to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings. 2. Our AMA will encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.  ~~3. Our AMA will study and report back on issues regarding student access to safe and effective overdose reversal medications.~~ |
| B | BOT 13 | n/a | Prohibiting Covenants Not-to-Compete | The Board of Trustees recommends that the following policy be adopted, and the remainder of the report be filed:  1. That the American Medical Association (AMA) continue to assist interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA’s state restrictive covenant legislative template. (New HOD Policy) |
| B | BOT 14 | n/a | Physician Assistant and Nurse Practitioner Movement Between Specialties | The Board of Trustees recommends that the following policy be adopted, and the remainder of the report be filed:  1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)  2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)  3. That the AMA encourage hospitals and other health care entities employing nurse practitioners to ensure that the nurse practitioner’s certification aligns with the specialty in which they will practice. (New HOD Policy)  4. That the AMA continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching. (New HOD Policy) |
| B | BOT 15 (1of4) | n/a | Augmented Intelligence Development, Deployment, and Use in Health Care | The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23 and that the remainder of the report be filed:  AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE  General Governance  • Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent. • Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration. • Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient. • Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)] • Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. • Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow. • Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)] |
| B | BOT 15 (2of4) | n/a | Augmented Intelligence Development, Deployment, and Use in Health Care | When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies  • When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request. • When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record. • AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician’s consent and final review.  • When health care content is generated by generative AI, including by large language models, it should be clearly disclosed within the content that was generated by an AI-enabled technology. • When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties. • The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. |
| B | BOT 15 (3of4) | n/a | Augmented Intelligence Development, Deployment, and Use in Health Care | • When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:   -Regulatory approval status  -Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology  -Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use  -Intended population and intended practice setting   -Clear description of any limitations or risks for use, including possible disparate impact  -Description of how impacted populations were engaged during the AI lifecycle  -Detailed information regarding data used to train the model:  •Data provenance  •Data size and completeness  •Data timeframes  •Data diversity  •Data labeling accuracy  -Validation Data/Information and evidence of:  •Clinical expert validation in intended population and practice setting and intended clinical outcomes  •Constraint to evidence-based outcomes and mitigation of “hallucination” or other output error  •Algorithmic validation  •External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation   •Comprehensiveness of data and steps taken to mitigate biased outcomes  •Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings  •Post-market surveillance activities aimed at ensuring continued safety, performance, and equity  -Data Use Policy  •Privacy  •Security  •Special considerations for protected populations or groups put at increased risk  -Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training  -Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review |
| B | BOT 15 (4of4) | n/a | Augmented Intelligence Development, Deployment, and Use in Health Care | • Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939] |
| B | BOT 16 | n/a | Support for Mental Health Courts | The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, “Support for Drug Courts” – be amended by addition and deletion in lieu of Resolution 202 as follows: Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs   Our AMA:  (1) supports the establishment and use of diversion and treatment programs ~~drug~~ ~~courts~~, including drug courts, mental health courts, veterans courts, sobriety courts, and other types of similar programs, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with a mental illness or substance use disorder involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~;  (2) encourages legislators and court systems to establish diversion and treatment programs ~~drug~~ ~~courts~~ at the state and local level in the United States; ~~and~~  (3) encourages diversion and treatment programs ~~drug~~ ~~courts~~ to rely upon evidence-based models of care, including medications for opioid use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and (4) supports individuals enrolled in diversion or treatment programs not be removed from a program solely because of evidence showing that an individual used illegal drugs while enrolled. (Modify HOD Policy) |
| B | BOT 17 | n/a | Drug Policy Reform | The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 203 and the remainder of the report be filed:  1.That the American Medical Association (AMA) will continue to monitor the legal and public health effects of state and federal policies to reclassify criminal offenses for drug possession for personal use; (New HOD Policy) 2. That the AMA will support federal and state efforts to expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; (New HOD Policy) and  3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy) |
| B | BOT 18 | n/a | Supporting Harm Reduction | The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204, and that the remainder of the report be filed. 1. That the American Medical Association (AMA) support efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder; (New HOD Policy) 2. That the AMA oppose the concept, promotion, or practice of “safe smoking” with respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy) 3. That the AMA encourage additional study whether “safer smoking supplies” may be a potential harm reduction measure to reduce harms from the nation’s overdose and death epidemic; and (New HOD Policy) 4. That the AMA reaffirm Policy D-95.987, “Prevention of Drug-Related Overdose.” (Reaffirm AMA Policy) |
| B | BOT 19 | n/a | Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication | The Board of Trustees recommends that the following be adopted in lieu of Resolution 240-A-23 and the remainder of this report be filed: 1. That our American Medical Association advocate that attorneys’ discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income) (New HOD Policy); and 2. RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert’s personal tax returns by attorneys within sixty days of the conclusion of the litigation (New HOD Policy). |
| B | Res. 201 | American Academy of Opthalmology | Research Correcting Political Misinformation and Disinformation on Scope of Practice | RESOLVED, that our American Medical Association perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice (Directive to Take Action);   RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the I-24 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA’s advocacy efforts on scope of practice. (Directive to Take Action) |
| B | Res. 202 | American Association of Clinical Urologists | Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims | RESOLVED, that our American Medical Association adopt as policy that Commercial third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health plans ensure they are making medical necessity determinations based on the circumstances of the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that does not account for an individual’s circumstances (New HOD Policy)  RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity determination must be reviewed by a physician in the same specialty or by another appropriate health care professional for non-physician health care providers. (New HOD Policy) |
| B | Res. 203 | Florida | Medicaid Patient Accountability | RESOLVED, that our American Medical Association advocate that physicians’ Healthcare Effectiveness Data and Information Set and other quality scores and ratings not be affected by non-compliant patients or patients whose parents exercise state exemptions from recommended treatment. (Directive to Take Action) |
| B | Res. 204 | Florida | Staffing Ratios in the Emergency Department | RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper supervision of NPPs in the Emergency Department (Directive to Take Action)  RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action) |
| B | Res. 205 | Medical Student Section | Medical-Legal Partnerships & Legal Aid Services | RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients’ legal needs. (New HOD Policy) |
| B | Res. 206 | Medical Student Section | Indian Health Service Youth Regional Treatment Centers | RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as a model for culturally-rooted, evidence-based behavioral health treatment, and prompt referral of eligible AI/AN youth to Youth Regional Treatment Centers (YRTCs) for community-directed care. (New HOD Policy) |
| B | Res. 207 | Medical Student Section | Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse | RESOLVED, that our American Medical Association support economic incentives to increase physician use of less expensive biosimilars instead of their reference biologics (New HOD Policy);   RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (New HOD Policy) |
| B | Res. 208 | Medical Student Section | Improving Supplemental Nutrition Programs | RESOLVED, that our American Medical Association support regulatory and legal reforms to extend multieligibility for USDA Food Assistance to enrolled members of federally-recognized American Indian and Alaska Native Tribes and Villages to all federal feeding programs, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR). (New HOD Policy) |
| B | Res. 209 | Medical Student Section | Native American Voting Rights | RESOLVED, that our American Medical Association support Indian Health Service, Tribal, and Urban Indian Health Programs becoming designated voter registration sites to promote nonpartisan civic engagement among the American Indian and Alaska Native population. (New HOD Policy) |
| B | Res. 210 | Oregon | Support for Physicians Pursuing Collective Bargaining and Unionization | RESOLVED, that our American Medical Association convenes an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action) |
| B | Res. 211 | Organized Medical Staff Section | Deceptive Hospital Badging 2.0 | RESOLVED, that our American Medical Association promote and prioritize public awareness of the difference and importance of having the proper level of training and clear identification and labeling of caregivers as that relates to quality and safety of healthcare (Directive to Take Action)  RESOLVED, that our AMA work with state and county medical societies to highlight to physicians the growing practice of creating false equivalencies between physicians and non-physicians in the healthcare team and encourage action in local institutions to assure the quality and safety of patient care. (Directive to Take Action) |
| B | Res. 212 | Organized Medical Staff Section | Advocacy Education Towards a Sustainable Medical Care System | RESOLVED, that our American Medical Association explore innovative opportunities for engaging the public in advocacy on behalf of an improved healthcare environment. (Directive to Take Action) |
| B | Res. 213 | Private Practice Physicians Section | Access to Covered Benefits with an Out of Network Ordering Physician | RESOLVED, that our American Medical Association develop model legislation to protect patients in direct primary care plans and non-network plans thus furthering the ability of direct primary care physicians and other out-of-network physicians to provide covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, even if it is an HMO or point of service plan (Directive to Take Action)  RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to support direct primary care and other out-of-network models. (Directive to Take Action) |
| B | Res. 214 | Medical Student Section | Support for Paid Sick Leave | RESOLVED, that our American Medical Association amend Policy H-440.823, “Paid Sick Leave,” as follows: Paid Sick Leave H-440.823 Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with paidsick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave. (Modify Current HOD Policy) |
| B | Res. 215 | Medical Student Section | American Indian and Alaska Native Language Revitalization and Elder Care | RESOLVED, that our American Medical Association recognize that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors (New HOD Policy);   RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands (New HOD Policy);   RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action) |
| B | Res. 216 | American College of Legal Medicine | The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act” | RESOLVED, that our American Medical Association support H.R. 7225, the bipartisan “Administrative Law Judges Competitive Service Restoration Act” that supports the merit-based process for the selection of all Medicare/Medicaid Administrative Law Judges. (New HOD Policy) |
| B | Res. 217 | American Society for Reproductive Medicine | Protecting Access to IVF Treatment | RESOLVED, that our American Medical Association oppose any legislation or ballot measures that could criminalize in-vitro fertilization (New HOD Policy);  RESOLVED, that our AMA work with other interested organizations to oppose any legislation or ballot measures or court rulings that equate gametes (oocytes and sperm) or embryos with children (New HOD Policy)  RESOLVED, that our AMA report back at A-25, on the status of, and AMA’s activities surrounding, ballot measures, court rulings, and legislation that equate embryos with children. (Directive to Take Action) |
| B | Res. 218 | Michigan | Designation of Descendants of Enslaved Africans in America | RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate if from the generic terms African American and Black in glossaries and on medical school applications. (Directive to Take Action) |
| B | Res. 219 | American College of Obstetricians and Gynecologists | Bundling for Maternity Care Services | RESOLVED, that our American Medical Association advocates for the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services. (Directive to Take Action) |
| B | Res. 220 | California | Restorative Justice for the Treatment of Substance Use Disorders | RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports providing incentives for incarcerated individuals to overcome substance use disorders, such as participation in treatment as a condition for early release, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy)  RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy) |
| B | Res. 221 | California | Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability | RESOLVED, that our American Medical Association support the creation of a new reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug, and 2) Ensures adequate compensation for the cost of acquisition, inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price (New HOD Policy)  RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. (New HOD Policy) |
| B | Res. 222 | Resident and Fellow Section | Studying Avenues for Parity in Mental Health & Substance Use Coverage | RESOLVED, that our American Medical Association study potential penalties to insurers for not complying with mental health and substance use parity laws. (Directive to Take Action) |
| B | Res. 223 | American Academy of Pediatrics | Increase in Children’s Hospital Graduate Medical Education Funding | RESOLVED, that our American Medical Association collaborate with other relevant medical organizations to support and advocate for increased funding for the Children’s Hospitals Graduate Medical Education program, recognizing the vital role it plays in shaping the future of pediatric healthcare in the United States. (Directive to Take Action) |
| B | Res. 224 | Medical Student Section | Antidiscrimination Protections for LGBTQ+ Youth in Foster Care | RESOLVED, that our American Medical Association collaborate with state medical societies and other appropriate stakeholders to support policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy)  RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist (New HOD Policy)  RESOLVED, that our AMA encourage child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) adopt programs to prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy) |
| B | Res. 225 | Medical Student Section | Humanitarian Efforts to Resettle Refugees | RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States. (New HOD Policy) |
| B | Res. 226 | Missouri | Protecting Access to IVF Treatment | RESOLVED, that our American Medical Association oppose any legislation that could criminalize in-vitro fertilization (New HOD Policy)  RESOLVED, that our AMA work with other interested organizations to oppose Court rulings that equate gametes (oocytes and sperm) or embryos with children. (Directive to Take Action) |
| B | Res. 227 | Missouri | Medicare Reimbursement for Telemedicine | RESOLVED, that our American Medical Association support removal of the December 31, 2024 “sunset” date currently set for Medicare to cease reimbursement for services provided via telemedicine, such that reimbursement of medical services provided by telemedicine be continued indefinitely into the future, consistent with what would be determined by the Relative Value Update Committee (“RUC”). (New HOD Policy) |
| B | Res. 228 | Missouri | Waiver of Due Process Clauses | RESOLVED, that our American Medical Association advocate that waiver of due process clauses be eliminated from all employment agreements between employed physicians and their non-physician employers, and be declared unenforceable in physicians’ previously-executed employment agreements between physicians and their non-physician employers that currently exist (Directive to Take Action)  RESOLVED, that our AMA will engage in advocacy for adoption of such legislation at the federal level. (Directive to Take Action) |
| B | Res. 229 | Illinois | Opposition to Legalization of Psilocybin | RESOLVED, that our American Medical Association oppose any legislative efforts relatable to legalization of Psilocybin/Psilocin or its related substances use. (New HOD Policy) |
| B | Res. 230 | American Academy of Dermatology | Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion | RESOLVED, that our American Medical Association advocacy efforts recognize the threat posed to patient safety when dentists and dental hygienists are authorized to practice medicine and administer procedures outside their level of education and training (New HOD Policy)  RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists and dental hygienists to practice outside their level of education and training. (Directive to Take Action) |
| B | Res. 231 | American College of Medical Genetics and Genomics | Supporting the Establishment of Rare Disease Advisory Councils | RESOLVED, that our American Medical Association will support state legislation for the establishment of Rare Disease Advisory Councils in each state (New HOD Policy) |
| B | Res. 232 | Association for Clinical Oncology | Medicare Advantage Part B Drug Coverage | RESOLVED, that our American Medical Association will advocate with Congress, through the appropriate oversight committees, and with the Centers for Medicare & Medicaid Services (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay (Directive to Take Action) |
| B | Res. 233 | Association for Clinical Oncology | Prohibiting Mandatory White Bagging | RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging (Directive to Take Action) |
| B | Res. 234 | Association for Clinical Oncology | State Prescription Drug Affordability Boards - Study | RESOLVED, that our American Medical Association conduct a study to determine how upper payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will impact reimbursement for physician-administered drugs and what impact state UPLs will have on patient access to care (Directive to Take Action)  RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at A-25. (Directive to Take Action) |
| B | Res. 235 | New Jersey | Establish a Cyber-Security Relief Fund | RESOLVED, that our American Medical Association, through appropriate channels, advocate for a ‘Cyber Security Relief Fund” to be established by Congress (Directive to Take Action)  RESOLVED, that the “Cyber Security Relief Fund” be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer (Directive to Take Action)  RESOLVED, that the “Cyber Security Relief Fund” only be utilized for ‘uninterrupted’ payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. (Directive to Take Action) |
| B | Res. 236 | Delaware | Support of Physicians Pursuing Collective Bargaining and Unionization | RESOLVED, that our American Medical Association investigate avenues for the AMA and other physician associations to aid physicians in initiating and navigating collective bargaining efforts, encompassing but not limited to unionization. (Directive to Take Action) |
| B | Res. 237 | American College of Preventive Medicine | Encouraging the Passage of the Preventive Health Savings Act (S.114) | RESOLVED, that our American Medical Association encourages continued advocacy to federal and state legislatures of the importance of more accurately and effectively measuring the health and economic impacts of investing in preventive health services to improve health and reduce healthcare spending costs in the long term. (Directive to Take Action)  RESOLVED, that our AMA reaffirm the following policy: D-155.994, “Value-Based Decision Making in the Health Care System” to encourage legislation and efforts to allow the Congressional Budget Office to more effectively project long-term budget deficit reductions and costs associated with legislation related to preventive health services. (Reaffirm HOD Policy) |
| B | Res. 238 | New York | AMA Supports Efforts to Fund Overdose Prevention Sites | RESOLVED, that our American Medical Association support legislation or regulation that would fund overdose prevention sites. (New HOD Policy) |
| B | Res. 239 | New York | Requiring stores that sell tobacco products to display NYS Quitline information | RESVOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the CDC hotline 1-800-QUIT-NOW in multiple languages and/or the information for the corresponding state or territory. (Directive to Take Action) |
| B | Res. 240 | New York | Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas | RESOLVED, that our American Medical Association supports reauthorization and expansion of the Conrad-30 J-1 visa waiver program, including permitting reallocation of unused slots to states that have already used the maximum number of waivers. (New HOD Policy) |
| B | Res. 241 | New York | Healthcare Cybersecurity Breaches | RESOLVED, that our American Medical Association advocate for the development of an adequately funded multidisciplinary task-force including representation of AMA, health insurers, the FBI and other pertinent stakeholders to prevent future healthcare cyberattacks throughout the country and to increase the apprehension of cybercriminals who prey on patients and healthcare entities, and to recommend appropriate penalties for their crimes. (Directive to Take Action) |
| B | Res. 242 | Minority Affairs Section | Cancer Care in Indian Health Services Facilities | RESOLVED, that our American Medical Association actively advocate for the federal government to continue enhancing and developing alternative pathways for American Indian and Alaska Native patients to access the full spectrum of cancer care and cancer-directed therapies outside of the established Indian Health Service system (Directive to Take Action)  RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS cancer care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage cancer linkage studies between the IHS and the CDC to better evaluate regional cancer rates, outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations. (Directive to Take Action) |
| B | Res. 243 | Minority Affairs Section | Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes | RESOLVED, that our American Medical Association add “Enrolled Member of a Federally Recognized Tribe” on all AMA demographic forms (Directive to Take Action);  RESOLVED, that our AMA advocate for the use of “Enrolled Member of a Federally Recognized Tribe” as an additional category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education (Directive to Take Action);   RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of “Enrolled Member of a Federally Recognized Tribe” on all AAMC demographic forms (New HOD Policy);   RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include “Enrolled Member of a Federally Recognized Tribe” on all ACGME demographic forms. (Directive to Take Action) |
| B | Res. 244 | Minority Affairs Section | Graduate Medical Education Opportunities for American Indian and Alaska Native Communities | RESOLVED, that our American Medical Association supports policy and communication efforts to (1) advance legislative and regulatory policies and actions that establish, authorize, fund, and incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities and (2) establish associated partnerships with accredited medical schools and teaching hospitals (New HOD Policy)  RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal organizations, academic medical centers, policy professionals, medical schools, teaching hospitals, coalition builders, and other stakeholders to advocate to Congress, The White House, the Department of Health and Human Services, and other government entities to establish dedicated graduate medical education funding and programs that benefit Tribal communities, increase physician training sites, and reduce physician shortages, particularly among underserved populations. (New HOD Policy) |
| C | BOT 31 | n/a | The Morrill Act and Its Impact on the Diversity of the Physician Workforce | The Board of Trustees that the following recommendations be adopted, and the remainder of this report be filed. That our AMA: 1. Amend AMA Support of American Indian Health Career Opportunities H-350.981 by addition to read:  (4) Our AMA will 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 to include training a workforce from and for these tribal nations.  (6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations. 2. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by deletion of clause (2) as having been accomplished by this report.   ~~(2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce~~. 3. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by addition of a new clause to read: Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students. 4. Reaffirm the following policies:  a. Indian Health Service H-350.977  b. Underrepresented Student Access to US Medical Schools H-350.960  c. Strategies for Enhancing Diversity in the Physician Workforce H-200.951  d.Continued Support for Diversity in Medical Education D-295.963  e. AMA Support of American Indian Health Career Opportunities D-350.976. @@ |
| C | CME 01 |  | Council on Medical Education Sunset Review of 2014 House of Delegates’ Policies | The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| C | CME 02 |  | The Current Match Process and Alternatives | The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed. That our AMA:  1. AMA Policy D-310.977, “National Resident Matching Program Reform” be amended by addition to read as follows. Our AMA: (20) Encourages the piloting of innovations to the residency application process with aims to reduce application numbers, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process. (21) Continues to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate. (Modify Current HOD Policy)  2. Reaffirm AMA Policies H-310.900 “Resident and Fellow Physicians Seeking to Transfer GME Program” and H-310.912 “Residents and Fellows’ Bill of Rights.” (Reaffirm HOD Policy)  3. Rescind AMA policy D-310.944, “Study of the Current Match Process and Alternatives,” as having been accomplished by this report. (Rescind HOD Policy) |
| C | Res. 301 | Medical Student Section | Fairness for International Medical Students | RESOLVED, that our American Medical Association encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students (New HOD Policy)  RESOLVED, that our AMA amend policy H-255.968 “Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools” by addition and deletion to read as follows; Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968 Our AMA:  1. supports the autonomy of medical schools to determine optimal tuition requirements for international students; 2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance; 3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); ~~and~~ 4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and 5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. (Modify Current HOD Policy);   RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools. (Directive to Take Action) |
| C | Res. 302 | Private Practice Physicians Section | The Role of Maintenance of Certification | RESOLVED, that our American Medical Association adopt a policy that states that maintenance of certification requirements should not be duplicative of continuing medical education requirements and not be used to determine or dictate hospital privileges, insurance network credentialing, or hiring practices (New HOD Policy)  RESOLVED, that our AMA recognizes the importance of fostering competition in the market for board certification, allowing physicians to have the autonomy to choose the most suitable pathway for their individual learning and professional development needs (New HOD Policy)  RESOLVED, that our AMA undertake a comprehensive review of the available evidence concerning the impact of maintenance of certification on the quality and safety of patient care and report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy with a report back to the House of Delegates by Annual 2025 (Directive to Take Action) |
| C | Res. 303 | Young Physicians Section | Amend Policy D-275.948 Title “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”. Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards. | RESOLVED, that our American Medical Association amend the title of policy D-275.948 by substitution and deletion as follows: ~~Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training~~ Addressing Non-physician Positions and Participation on Physician Regulatory Boards and Bodies and Potential Conflicts of Interest D-275.948 (Modify Current HOD Policy)  RESOLVED, that our AMA work with relevant stakeholders and regulatory bodies and boards involved in physician education, accreditation, certification, licensing, and credentialing to advocate for physician leadership of these regulatory bodies and boards in order to be consistent with the AMA Recovery Plan’s efforts to fight scope creep, and prevent undermining physician confidence in these organizations (Directive to Take Action)  RESOLVED, that our AMA create a task force with the mission to increase physician awareness of and participation in leadership positions on regulatory bodies and boards involved in physician education, accreditation, certification, licensing, and credentialing through mechanisms including but not limited to mentorship programs, leadership training programs, board nominations, publicizing the opportunities to the membership, and creating a centralized list of required qualifications and methods to apply for these positions. (Directive to Take Action) |
| C | Res. 304 | Academic Physicians Section | Spirituality in Medical Education and Practice | RESOLVED, that our American Medical Association amend Policy H-160.900 to read as follows:  ~~Addressing~~ Patient Spirituality in ~~Medicine~~ Medical Education and Practice  (1) Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services.  (2) Our AMA encourages the availability of education about spiritual health, defined as meaning, purpose, and connectedness, in curricula in medical school, graduate medical education, and continuing physician professional development as an integral part of whole person care, which could include:  (a) assessing spiritual health as part of the history and physical;  (b) addressing treatment of spiritual distress by the clinician, with appropriate referral to spiritual care professionals;  (c) acknowledging patients’ spiritual resources;  (d) developing compassionate listening skills;  (e) ensuring ongoing follow-up of patients’ spiritual health by clinicians as appropriate;  (f) describing respect for the spiritual, religious, existential, and cultural value of those they serve and understanding why it is important to not impose their own personal values and beliefs on those served; and  (g) self-reflection on one’s own spirituality within professional development courses, especially as related to their vocation and wellbeing. (Modify Current HOD Policy) |
| C | Res. 305 | Oklahoma | Public Service Loan Forgiveness Reform | RESOLVED, that our American Medical Association amend Indian Health Service H-350.977 by addition and deletion as follows:  Indian Health Service H-350.977 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) Personnel Manpower: (a) Compensation scales 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 specialty and primary care service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing 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 without detracting from physician compensation; (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 burnout; 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. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. (8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy) |
| C | Res. 306 | Edmond Cabbabe, MD | Unmatched Graduating Physicians | RESOLVED, that our American Medical Association Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the House of Delegates at the next Interim meeting. (Directive to Take Action) |
| C | Res. 307 | California | Access to Reproductive Health Services When Completing Physician Certification Exams | RESOLVED, that our American Medical Association encourage national specialty boards who hold in-person centralized mandatory exams for board certification to offer alternative methods of taking mandatory board certification examinations, such as virtual boards examinations, or to locate them outside of states that are in the process of banning or restricting or that have banned or restricted abortion, gender affirming care or reproductive healthcare services. (New HOD Policy) |
| C | Res. 308 | Resident and Fellow Section | Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being | RESOLED, that our AMA supports changing USMLE Step 3 from a two-day examination to a one-day examination (New HOD Policy)  RESOLVED, that our AMA supports the option to take USMLE Step 3 after passing Step 2-Clinical Knowledge (CK) during medical school (New HOD Policy)  RESOLVED, that our AMA advocates that residents taking the USMLE Step 3 exam be allowed days off to take the exam without having this time counted for PTO or vacation balance. (Directive to Take Action) |
| C | Res. 309 | Resident and Fellow Section | Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine | RESOLVED, that our American Medical Association recognizes that the Alpha Omega Alpha Honor Medical Society disproportionately benefits privileged trainees (New HOD Policy)  RESOLVED, that our AMA supports institutional disaffiliation from the Alpha Omega Alpha Honor Medical Society due to its perpetuation of racial inequities in medicine (New HOD Policy)  RESOLVED, that our AMA recognizes that the Alpha Omega Alpha Honor Medical Society perpetuates and accentuates discrimination against trainees of color that is inherent in medical training. (New HOD Policy) |
| C | Res. 310 | Pennsylvania | Accountability & Transparency in GME funding with Annual Report | RESOLVED, that our American Medical Association work with interested parties (including but not limited to the CMS, VA, DOD and others) to issue an annual report detailing the quantity of GME funding for each year including how those funds are allocated on a per resident or fellow basis, for a minimum of the previous 5 years (Directive to Take Action)  RESOLVED, that our AMA reaffirm policy H 305.929 (Last modified 2016). (Reaffirm HOD Policy) |
| C | Res. 311 | Pennsylvania | Physician Participation in Healthcare Organizations | RESOLVED, that our American Medical Association reaffirm H 405.953. (Reaffirm HOD Policy) |
| C | Res. 312 | Georgia | AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians | RESOLVED, that our American Medical Association work with the FSMB, specialty and subspecialty societies, and other relevant stakeholders to study and develop evidence-based criteria for determining a physician’s readiness to reenter practice and identify resources for the evaluation and retraining of physicians seeking to reenter active practice. (Directive to Take Action) |
| C | Res. 314 | Women Physicians Section | Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule | RESOLVED, that our American Medical Association collaborate with higher education authorities to research physician career outcomes and explore financial value transparency among higher educational institutional programs that grant professional and doctoral degrees beyond six years following graduation in light of the new gainful employment regulations and transparency provisions that will take effect July 1, 2024 (Directive to Take Action)  RESOLVED, that our AMA continue to work with key stakeholders and advocate for the resolution of the student loan crisis to protect physicians from unaffordable student debt and poor earning outcomes. (Directive to Take Action) |
| C | Res. 315 | Maryland | Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations | RESOLVED, that our American Medical Association advocate that NBME and NBOME cease reporting the total number of attempts of the STEP1 and COMLEX-USA Level 1 examinations to residency and fellowship programs and licensure. (Directive to Take Action) |
| C | Res. 316 | New England | Reassessment of Continuing Board Certification Process | RESOLVED, that our American Medical Association undertake a thorough review and analysis of the available literature, data, and evidence to re-examine and update the accepted standards for continuing board certification including policy H-275.926, Medical Specialty Board Certification Standards, so the standards reflect the best manner to assess physicians’ knowledge and skills necessary to practice medicine. (Directive to Take Action) |
| C | Res. 317 | New York | Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians | RESOLVED, that our American Medical Association petition the Accredited Continuing Medical Education to develop policies which require physician participation in the planning and development of accredited continuing education for physicians. (Directive to Take Action) |
| C | Res. 318 | American Urological Association | Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care | RESOLVED, that our American Medical Association work with the American Board of Medical Specialties to study the variation in board certification requirements for internationally trained physicians as well as the impact this may have on physician practices and addressing physician shortages including the impact of these pathways on maintaining public assurance of a well-trained physician workforce (Directive to Take Action)  RESOLVED, that our AMA study the potential effects of increasing access to board certification for internationally-trained physicians on projected physician workforce shortages (Directive to Take Action)  RESOLVED, that our AMA work with the Federation of State Medical Boards to study the existing alternate pathways to licensure for physicians who have not completed an ACGME-accredited post-graduate training program and the positive and negative impacts of these pathways on addressing physician shortages. (Directive to Take Action) |
| C | Res. 319 | Minority Affairs Section | AMA Support of U.S. Pathway Programs | RESOLVED, that our American Medical Association establish a grant program to support existing and new K-16 pathway, STEMM and pre-med programs whose goals include, scaling organizational grantees’ ability to expand their reach among youth; increasing diversity in medicine; achieving health equity; improving medical education (Directive to Take Action)  RESOLVED, that our AMA establish a diverse advisory body comprised of AMA member physicians and trainees, staff, and allied organization representatives in medicine and public health to co-develop the grant program (i.e., administration; grantee criteria and selection; periodic reporting) (Directive to Take Action)  RESOLVED, that our AMA convene a summit among pathway and STEMM programs regarding best practices, collaboration and strategic planning. (Directive to Take Action) |
| C | Res. 313 | Oklahoma | CME for Rural Preceptorship | RESOLVED, that our American Medical Association along with the Council of Medical Education, formulate a “toolkit” to teach physicians who serve as preceptors, especially in rural and underserved areas, how to be better preceptors and the process on claiming AMA Category 1 credits for preparation and teaching medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions, thereby making them a more effective preceptor (Directive to Take Action)  RESOLVED, that our AMA study formulating a plan, in collaboration with other interested bodies, to award AMA Category 1 credits to physicians who serve as preceptors in rural and underserved areas teaching medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions thereby improving the rural healthcare workforce shortage (Directive to Take Action)  RESOLVED, that our AMA devise a method of converting those credits awarded by other organizations into AMA recognized credits for the purpose of CME. (Directive to Take Action) |
| D | CSAPH 03 |  | Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.  1. That AMA Policy H-440.797, “Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders,” be amended by addition to read as follows:   1. Our AMA recognizes:  1. the issues with using body mass index (BMI) as a measurement because: (a) the eugenics behind the history of BMI, (b) the use of BMI for racist exclusion, and (c) BMI cutoffs are based on the imagined ideal Caucasian and does not consider a person’s gender or ethnicity.  2. the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors.  3. that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level. 4. that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity.  5. that in some diagnostic circumstances, the use of BMI should not be used as a sole criterion for appropriate insurance reimbursement.  6. the use of BMI within the context of comorbidities, baseline mortality risk, and environmental factors such as chronic stressors, poor nutrition, and low physical activity may be used for risk stratification.  7. BMI is a widely used tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconstancies, but BMI does not fully capture the complexity of the obesity epidemic.  8. that BMI, in combination with other anthropometric measures and environmental factors, may be useful as an initial screener to identify individuals for further investigation of metabolic health risks.   2. Our AMA supports further research on the application of the extended BMI percentiles and z-scores and its association with other anthropometric measurements, risk factors, and health outcomes.  3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative measures for diagnosing obesity. (Amend HOD Policy) |
| D | CSAPH 06 |  | Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.  1. That Policy H-160.932, “Asthma Control” be amended by addition and deletion to read as follows: The AMA: (1) encourages physicians to make appropriate use of evidence-based guidelines, including those contained in ~~Expert Panel Report III: Guidelines for the Diagnosis and Management of Asthma released by the National Heart, Lung and Blood Institute and~~ the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group 2020 Focused Updates to the Asthma Management Guidelines; (2) encourages physicians to provide self-management education tailored to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use of a written asthma action plan, taking medication correctly, and avoiding environmental factors that worsen asthma; ~~and~~ (3) encourages physicians to incorporate the four components of care (assessment and monitoring; education; control of environmental factors and comorbid conditions; and appropriate medication selection and use)~~.;~~ and (4) will, in collaboration with interested parties and organizations, develop content to help physicians talk through the different asthma control options and their known economic costs and environmental impacts. (Modify Current AMA Policy)   2. That Policy H-135.913, “Metered Dose Inhalers and Greenhouse Gas Emissions” be amended by addition and deletion to read as follows:  1. Our AMA will advocate to reduce the climate effects of hydrofluorocarbon propellants in metered-dose inhalers and encourage strategies ~~for encouraging~~ supporting the development and use of alternative inhalers and propellants with equal and or higher efficacy and less adverse effect on our climate.  2. Our AMA ~~will advocate for~~ supports legislative and regulatory reforms~~,~~ that increase access to affordable ~~to keep~~ inhalers ~~medications affordable and accessible, will urge FDA to consider metered-dose inhaler propellant substitutions for the purposes of climate protection as drug reclassifications,~~ with lower greenhouse gas emissions that align with current recommended standards of care. Reforms should aim to ensure the quality of patents issued on new drug-device combinations, prevent new patents for minor changes made to delivery systems, and remove barriers to market entry for generic inhalers.   3. Our AMA supports consideration of the environmental impacts of inhalers when creating prescription drug formularies and for the federal government to factor environmental impact into price negotiations with pharmaceutical manufacturers. ~~without new patent or exclusivity privileges, and not allow these substitutions to classify as new drug applications.~~ ~~3. Our AMA will study options for reducing hydrofluorocarbon use in the medical sector.~~ (Modify Current AMA Policy)  3. That the following new policy be adopted. REDUCING ENVIRONMENTAL IMPACTS OF ANESTHETIC GASES The AMA, in collaboration with interested parties and organizations, will disseminate evidence-based content and recommended strategies to reduce the global warming impact of anesthetic gases and encourage the phasing out of desflurane as an anesthetic gas. (New HOD Policy) |
| D | CSAPH 09 |  | Prescribing Guided Physical Activity for Depression and Anxiety | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.  1. That our AMA amend policy H-470.997, “Exercise and Physical Fitness” by addition and deletion to read as follows:   Exercise and Physical Fitness H-470.997 1. Our AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means.  ~~Our AMA will study evidence of the efficacy of physical activity interventions (i.e., group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety symptoms.~~  2. Our AMA advocates for continued research towards development of structured physical activity treatment plans for the specific diagnoses of anxiety and depression, as well as longitudinal studies to examine the effects of physical activity on health outcomes, particularly later in life.  3. Our AMA encourages:  1. education of health care professionals on the role of physical activity and/or structured exercise in treating and managing anxiety and depression and the need to screen, motivate, and educate patients of all ages about the benefits of physical activity, including positive mental health benefits.  2. health care payers and employers to provide coverage for gym memberships and access to other physical activity programs.  3. the implementation, trending, and utilization of physical activity measures, such as physical activity vital signs (PAVS), in the medical record for treatment prescription, counseling, coaching, and follow up of physical activity for therapeutic use. (Modify HOD Policy) |
| D | CSAPH 10 | n/a | Teens and Social Media | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:  1. That our AMA: (1) urges physicians to: (a) educate themselves about social media; (b) be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and (c) consider expanding clinical interviews to inquire about social media use.  (2) encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health. (3) supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media.  (4) recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment).  (5) supports legislative, regulatory, and associated initiatives (e.g., development of industry standards, age-appropriate design, and funding programs that support those harmed by online harassment). (6) will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment. (New HOD Policy)  2. That current AMA policy D-478.965, “Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965” be amended by addition and deletion to read as follows:   Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians’ knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs ~~by which~~ so that (a) all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage, (b) all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media), and (c) at risk students’ access to social media can be limited and/or closely monitored as individually appropriate; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users, including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and development and dissemination of age-appropriate digital literacy training; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use. (Modify Current HOD Policy) |
| D | CSAPH 11 |  | Stand Your Ground Laws | The Council on Science and Public Health recommends that the following be adopted and the remainder of this report be filed.  1. That Policy H-145.966, “Stand Your Ground Laws” be adopted by addition and deletion to read as follows:  Our AMA opposes stand your ground laws, which remove the duty to retreat before using lethal force if a person feels there is imminent risk of bodily harm, as these laws have been shown to increase homicide and homicide firearm rates and there is evidence of racial inequity in the implementation of the laws.  Our AMA ~~will~~ supports continued study of the public health implications of “Stand Your Ground” laws and castle doctrine. (Modify Current HOD Policy)  2. That Policies H-145.997, “Firearms as a Public Health Problem in the United States - Injuries and Death,” D-145.995, “Gun Violence as a Public Health Crisis,” H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” and D-145.999 “Epidemiology of Firearm Injuries” be reaffirmed. (Reaffirm HOD Policy) |
| D | CSAPH 13 | n/a | Decreasing Youth Access to E-Cigarettes | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:  1. That our AMA supports the inclusion of all forms of e-cigarettes (e.g., disposable, refillable cartridge, and tank-based e-cigarettes) in the language and implementation of relevant nicotine-based policies and regulations by the Food and Drug Administration or other regulatory agencies. (New HOD Policy) 2. That current AMA Policy H-495.986, “Tobacco Product Sales and Distribution,” be amended by addition to read as follows:   Tobacco Product Sales and Distribution, H-495.986 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;  (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;  (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;  (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;  (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and  (9) opposes the sale of tobacco at any facility where health services are provided; and  (10) supports measures that decrease the overall density of tobacco specialty stores, including but not limited to, preventing retailers from opening new tobacco specialty stores in close proximity to schools. (Modify Current AMA Policy)  That our AMA reaffirm Policies H-495.970, “Regulation of “Cool/Non-Menthol” Tobacco Products, H-495.971 “Opposition to Addition of Flavors to Tobacco Products,” and H-495.976, “Opposition to Exempting the Addition of Menthol to Cigarettes.” (Reaffirm HOD Policy) |
| D | Res. 401 | Integrated Physician Practice Section | Addressing Social Determinants of Health Through Closed Loop Referral Systems | RESOLVED, that our American Medical Association study the effectiveness and best practices of closed loop referral systems in addressing social determinants of health. (Directive to Take Action) |
| D | Res. 402 | Medical Student Section | Guardianship and Conservatorship Reform | RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy)  RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life. (Directive to Take Action) |
| D | Res. 403 | Medical Student Section | Occupational Screenings for Lung Disease | RESOLVED, that our American Medical Association amend Policy H-365.988, “Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies” by addition and deletion as follows:  Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies, H-365.988 Our AMA ~~supports~~: (1) supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) supports taking a leadership role in assisting state medical societies in implementation of such programs; ~~and~~ (3) supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognizes barriers to accessibility and utilization of such programs; (5) recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase accessibility of these screenings in marginalized communities; and (6) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings. (Modify Current HOD Policy) |
| D | Res. 404 | Medical Student Section | Protections Against Surgical Smoke Exposure | RESOLVED, that our American Medical Association support efforts to limit surgical smoke exposure in operating rooms. (New HOD Policy) |
| D | Res. 405 | Medical Student Section | Default Proceed Firearm Sales and Safe Storage Laws | RESOLVED, that our American Medical Association amend Policy H-145.996, “Firearm Availability,” by addition as follows  Firearm Availability H-145.996 1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; (c) opposes firearm sales to individuals for whom a background check has not been completed; (d) opposes destruction of any incomplete background checks for firearm sales; (e) advocates for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state lines, or via other means; and average time passed between background check completion and retrieval; and (f~~c~~) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms 3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored. 4. Our AMA advocates for (a) federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure; (b) federal and state policies to prevent “multiple sales” of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and (c) federal and state policies implementing background checks for ammunition purchases  RESOLVED, that our American Medical Association amend Policy H-145.990, “Prevention of Firearm Accidents in Children,” by addition as follows:  1) Our AMA (a) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (i) inquire as to the presence of household firearms as a part of childproofing the home; (ii) educate patients to the dangers of firearms to children; (iii) encourage patients to educate their children and neighbors as to the dangers of firearms; and (iv) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(b) encourages state medical societies to work with other organizations to increase public education about firearm safety; (c) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (d) supports enactment of Child Access Prevention laws and other types of comprehensive safestorage laws that are consistent with AMA policy. 2) Our AMA and all interested medical societies wil (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter. |
| D | Res. 406 | Medical Student Section | Opposition to Pay-to-Stay Incarceration Fees | RESOLVED, that our American Medical Association oppose fees charged to incarcerated individuals for room and board and advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board |
| D | Res. 407 | Medical Student Section | Racial Misclassification | RESOLVED, that our American Medical Association amend H-85.953, “Improving Death Certification Accuracy and Completion,” by addition as follows: Improving Death Certification Accuracy and Completion H-85.953 1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it. 2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians. 3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.  4. Our AMA further supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification. (Modify Current HOD Policy) |
| D | Res. 408 | Medical Student Section | Indian Water Rights | RESOLVED, that our American Medical Association raise awareness about ongoing water rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in appropriate forums (Directive to Take Action)  RESOLVED, that our AMA support improving access to water and adequate sanitation, water treatment, and environmental support and health services on American Indian and Alaska Native trust lands. (New HOD Policy) |
| D | Res. 409 | Medical Student Section | Toxic Heavy Metals | RESOLVED, that our American Medical Association urge governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air (Directive to Take Action)  RESOLVED, that our AMA support efforts to monitor and educate individuals on (a) the chronic effects of exposure to toxic heavy metals including at levels below regulation limits, and (b) the burden of toxicity in communities, especially near urban, Superfund, and industrial sites. (New HOD Policy) |
| D | Res. 410 | Medical Student Section | Access to Public Restrooms | RESOLVED, that our American Medical Association support access to clean, accessible, and permanent public restrooms that, at minimum, contain a toilet and sink, regardless of any identifying characteristics such as gender identity, appearance, employment status, or commercial status (New HOD Policy)  RESOLVED, that our AMA support parity in restroom access by gender identity, including increasing the number of female and gender-neutral bathrooms available in both new and existing buildings. (New HOD Policy) |
| D | Res. 411 | Oklahoma | Missing and Murdered Indigenous Persons | RESOLVED, that our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on reservations and in urban areas. (New HOD Policy) |
| D | Res. 412 | Indiana | Lithium Battery Safety | RESOLVED, that our American Medical Association seek legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries. (Directive to Take Action) |
| D | Res. 413 | Michigan | Sexuality and Reproductive Health Education | RESOLVED, that our American Medical Association reaffirm AMA Policy H-170.968, “Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,” and continue to advocate for the adoption of developmentally appropriate, culturally sensitive, comprehensive sexuality and reproductive health education and reproductive rights curriculum. (Reaffirm HOD Policy) |
| D | Res. 414 | California | Addressing the Health Sector’s Contributions to the Climate Crisis | RESOLVED, that our American Medical Association recognizes that clinical quality and safety should not be sacrificed as strategies for reducing greenhouse gasses and waste (New HOD Policy);  RESOLVED, that our AMA recognizes that animal-based agriculture is a significant contributor to greenhouse gas emissions and supports efforts to increase and promote plant-based menu options in hospital food services, for both health and environmental reasons (New HOD Policy);  RESOLVED, that our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions (New HOD Policy);  RESOLVED, that our AMA opposes corporate “greenwashing,” or the act of making misleading statements about the environmental benefits of products and/or services (New HOD Policy);  RESOLVED, that our AMA supports the development of locally managed and reliable electrical microgrids that operate independently from the larger electrical grid for hospitals and other health care facilities to use as a way to reduce reliance on diesel generation for back-up services while maintaining critical care functions during emergencies and supports grants being provided to independent practices to facilitate this development (New HOD Policy);  RESOLVED, that our AMA supports the use of virtual health care, where appropriate, with reasonable reimbursement, as a strategy to reduce the carbon footprint of health care (New HOD Policy);  RESOLVED, that our AMA support financial assistance for health care entities, including community health centers, clinics, rural health centers, small- and medium-sized physician practices, transitioning to environmentally sustainable operations (New HOD Policy);  RESOLVED, that our AMA support the development of concise clinical guidelines and patient education materials to assist physician practices and patients to reduce adverse organizational and personal impacts on climate change. (New HOD Policy) |
| D | Res. 415 | California | Building Environmental Resiliency in Health Systems and Physician Practices | RESOLVED, that our American Medical Association support a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change (New HOD Policy)  RESOLVED, that our AMA encourage health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities (New HOD Policy)  RESOLVED, that our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity. (New HOD Policy) |
| D | Res. 416 | California | Furthering Environmental Justice and Equity | RESOLVED, that our American Medical Association support state and local climate-health risk assessments, disease surveillance and early warning systems, and research on climate and health, with actions to improve and/or correct the findings (New HOD Policy)  RESOLVED, that our AMA support measures to protect frontline communities from the health harms of proximity to fossil fuel extraction, refining and combustion, such as the best available technology to reduce local pollution exposure from oil refineries, or health safety buffers from oil extraction operations (New HOD Policy)  RESOLVED, that our AMA support prioritizing greenspace access and tree canopy coverage for communities that received a “D” rating from the Home Owners’ Loan Corporation, otherwise known as being “redlined,” or that have been impacted by other discriminatory development and building practice, thereby protecting residents of these communities from displacement. (New HOD Policy) |
| D | Res. 417 | California | Reducing Job-Related Climate Risk Factors | RESOLVED, that our American Medical Association support enforcement of existing outdoor health standards and the establishment of enforceable indoor heat and outdoor cold illness prevention standards, for occupational settings, schools, licensed health care and other congregate facilities. (New HOD Policy) |
| D | Res. 418 | Resident and Fellow Section | Early and Periodic Eye Exams for Adults | RESOLVED, that our American Medical Association amend policy H-25.990 “Eye Exams for the Elderly” by addition to read as follows:Eye Exams for the Elderly and Adults H-25.990Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients and adults who suffer from chronic systemic conditions that increase their likelihood of developing eye disease as well as a baseline eye examination for all adults aged 40 and above. (2) Our AMA encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.(Modify Current HOD Policy) |
| D | Res. 419 | Medical Student Section | Addressing the Health Risks of Extreme Heat | RESOLVED, that our American Medical Association support funding for subsidizing energy costs and air conditioning units for low-income households to maintain safe temperatures during periods of extreme temperature (New HOD Policy)  RESOLVED, that our AMA support the implementation and enforcement of state and federal temperature standards in prisons, jails, and detention centers, including the implementation of air conditioning in areas that experience dangerously high temperatures. (New HOD Policy) |
| D | Res. 420 | Pennsylvania | Equity in Dialysis Care | RESOLVED, that our American Medical Association declare kidney failure as a significant public health problem with disproportionate affects and harm to under-represented communities (New HOD Policy))  RESOLVED, that our AMA vigorously pursue potential solutions and partnerships to identify economic, cultural, clinical and technological solutions that increase equitable access to all modalities of care including home dialysis. (Directive to Take Action) |
| D | Res. 421 | American Society for Metabolic and Bariatric Surgery | Annual Conference on the State of Obesity and its Impact on Disease in America (SODA) | RESOLVED, that our American Medical Association convene an annual meeting of its Federation partners to comprehensively review the impact of obesity on hypertension, cardiovascular disease, type 2 diabetes, metabolic dysfunction-associated hepatitis (MASH) and other related comorbidities with a focus on monitoring epidemiology, developing algorithms to combat disease progression, and coordinating efforts to improve access to care (Directive to Take Action);  RESOLVED, that our AMA shall feature presentations, workshops, and panel discussions covering the latest research findings, clinical guidelines, and best practices related to the prevention, diagnosis, and management of obesity-related chronic diseases (Directive to Take Action);  RESOLVED, that our AMA shall invite renowned experts, researchers, clinicians, policymakers, and patient advocates to contribute their insights, experiences, and recommendations during the annual meeting (Directive to Take Action);  RESOLVED, that our AMA shall collaborate with relevant stakeholders, including government agencies, healthcare systems, insurers, community organizations, and industry partners, to develop and implement strategies for combating obesity-related chronic diseases (Directive to Take Action) RESOLVED, that our AMA assist in the discussion of epidemiological trends, development of evidence-based algorithms for disease management, and coordination of efforts to improve access to care for patients affected by obesity-related chronic diseases (Directive to Take Action) RESOLVED, that our AMA shall publish a comprehensive report summarizing the discussions, findings, and recommendations from each annual meeting and disseminate it to member organizations, policymakers, healthcare providers, and the public (Directive to Take Action) RESOLVED, that the AMA shall convene the first annual meeting in 2025 and subsequent meetings annually thereafter. (Directive to Take Action) |
| D | Res. 422 | Ohio | Immunization Registry | RESOLVED, that our American Medical Association develop model legislation requiring all vaccine providers to participate in their statewide immunization information system (Directive to Take Action)  RESOLVED, that our AMA support mandating all vaccine providers to report all immunizations to their respective state immunization registry, for both adults and children (New HOD Policy)  RESOLVED, that our AMA support reimbursement for reporting immunizations to state registries by both public and private payers. (New HOD Policy) |
| D | Res. 423 | Senior Physicians Section | HPV Vaccination to Protect Healthcare Workers over Age 45 | RESOLVED, that our American Medical Association support all health care workers (HCWs) who might be exposed to HPV in the course of their clinical duties and strongly encourage them to wear masks, preferably N-95 (New HOD Policy)  RESOLVED, that our AMA will work with appropriate stakeholders to ensure that the HPV vaccine should be offered to all HCWs with potential exposure to HPV oncogenic material at no or minimal cost to the HCW individual (Directive to Take Action)  RESOLVED, that our AMA work with relevant stakeholders, including the CDC, to recommend HPV vaccine to HCWs to prevent health care related transmission. (Directive to Take Action) |
| D | Res. 424 | Senior Physicians Section | LGBTQ+ Senior Health | RESOLVED, that our American Medical Association create and disseminate educational initiatives to increase awareness and understanding of senior LGBTQ+ health aging issues among the general public, healthcare professionals, and policy makers (Directive to Take Action)  RESOLVED, that our AMA develop and promote cultural competency training for clinicians in caring for senior LGBTQ+ individuals (Directive to Take Action);  RESOLVED, that our AMA develop and promote policies and practices for implementation within all healthcare settings that are inclusive and affirming for LGBTQ+ seniors (Directive to Take Action)  RESOLVED, that our AMA advocate for increased funding and resources for research into health issues of LGBTQ+ seniors. (Directive to Take Action) |
| D | Res. 425 | Women Physicians Section | Perinatal Mental Health Disorders among Medical Students and Physicians | RESOLVED, that our American Medical Association work with relevant stakeholders to identify ways to increase screening for perinatal mental health conditions and reduce stigma surrounding the diagnosis and treatment of perinatal mental health conditions (Directive to Take Action)  RESOLVED, that our AMA advocate for reducing structural and systemic barriers to the diagnosis and treatment of perinatal mental health conditions in physicians and medical students. (Directive to Take Action) |
| D | Res. 426 | New Jersey | Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action | RESOLVED, that our American Medical Association policy no. D-245.994 be amended to include the importance of all women achieving their healthiest weight before pregnancy, maintaining healthy gestational weight gain, and optimizing weight loss postpartum (Modify Current HOD Policy)  RESOLVED, that our AMA: a) Advocate for access to effective obesity treatment (either medical or surgical) for patients.  b) Advocate for supporting physicians’ ability to provide obstetrical and obesity care. c) Advocate for additional funding for research on medical technology that influences human behavior to promote healthy living. d) Reaffirm policy no. H-440.902 and report back at A-25 on research on the medical, psychological, and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity, emphasizing pre-conception, gestational and postpartum obesity. e) Provide medical recommendations on ways to eliminate barriers identified in prior obesity research by our AMA.  f) Recommend that approaches to obesity prevention and treatment be included as an element of medical education.(Directive to Take Action) |
| D | Res. 428 | New England | Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals | RESOLVED, that our American Medical Association improve physician and public education around the adverse health effects of PFAS and potential mitigation and prevention efforts. (Directive to Take Action) |
| D | Res. 429 | New England | Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants | RESOLVED, that our American Medical Association advocate for strict limitations of aerosol, soil, and/or water radionuclide releases in the decommissioning of US nuclear power plants in order to protect health, particularly that of local vulnerable populations. (Directive to Take Action) |
| D | Res. 430 | New England | Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages | RESOLVED, that our American Medical Association advocate for information about lung cancer screening to be included within all combustible tobacco product packaging (Directive to Take Action)  RESOLVED, that our AMA will work with appropriate public health organizations and governmental agencies to monitor the impact of “non-combustible tobacco” nicotine delivery devices on cancer epidemiology and promote appropriate cancer screening should the suspected link be proven. (Directive to Take Action) |
| D | Res. 431 | Massachusetts | Combatting the Public Health Crisis of Gun Violence | RESOLVED, that our American Medical Association advocate for and strongly support legislation, regulation, and reform that seeks to address the public health crisis posed by gun violence. (Directive to Take Action) |
| D | Res. 432 | American College of Preventive Medicine | Resolution to Decrease Lead Exposure in Urban Areas | RESOLVED, that our American Medical Association reaffirm the following policy H-135.928, “Safe Drinking Water” in support of EPA’s Lead and Copper Rule and evidence-based research demonstrating there is no safe level of lead for humans and therefore warrants immediate Federal, State, and municipal action (Reaffirm HOD Policy)  RESOLVED, that our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant women, newborns and young children, with the provision of accessible water filters in homes found to have elevated lead levels in potable water (Directive to Take Action)  RESOLVED, that our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies (New HOD Policy)  RESOLVED, that our AMA promotes community awareness and education campaigns on the causes and risks of lead and drinking water and steps that can be taken to eliminate these risks (Directive to Take Action)  RESOLVED, that our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure (Directive to Take Action)   RESOLVED, that our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas (Directive to Take Action)  RESOLVED, that our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies (Directive to Take Action) |
| D | Res. 433 | Minority Affairs Section | Improving Healthcare of Rural Minority Populations | RESOLVED, that our AMA encourage federal, state and local governments of the unique health and health-related needs of rural minorities in an effort to improve their quality of life (New HOD Policy)  RESOLVED, that our AMA encourage the collection of vital statistics and other relevant demographic data of rural minorities (New HOD Policy)  RESOLVED, that our AMA encourage organizations of the importance of rural minority health (New HOD Policy)  RESOLVED, that our AMA research and study health issues unique to rural minorities, such as access to care difficulties (Directive to Take Action)  RESOLVED, that our AMA channel existing policy for telehealth to support rural minority communities (Directive to Take Action)  RESOLVED, that our AMA will encourage our Center for Health Equity to support rural minority health through programming, equity initiatives, and other representation efforts. (New HOD Policy) |
| D | Res. 427 | New England | Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals | RESOLVED, that our American Medical Association condemns the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals and outpatient health care settings (New HOD Policy)  RESOLVED, that our AMA advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate (Directive to Take Action)  RESOLVED, that our AMA advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians. (Directive to Take Action) |
| E | CSAPH 01 | n/a | Council on Science and Public Health Sunset Review of 2014 House Policies | The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action) |
| E | CSAPH 02 | n/a | Comparative Effectiveness Research | The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:  (1) That policy H-450.922, “Comparative Effectiveness Research” be amended by deletion to read as follows:  Our AMA will: ~~(1) 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) (1)~~ 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. (Amend HOD Policy)  (2) That policies H-120.988, “Patient Access to Treatments Prescribed by Their Physicians”, and H-460.909, “Comparative Effectiveness Research” be reaffirmed. (Reaffirm HOD Policy) |
| E | CSAPH 04 | n/a | Sex and Gender Differences in Medical Research | The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:  That policy H-525.988, “Sex and Gender Differences in Medical Research” be amended by addition and deletion to read as follows: 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 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; (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; and (6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities.; and (7) supports the FDA’s requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women, and sex and gender minorities; and (8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sex and gender minorities when those groups were not adequately represented in clinical trials; and (9) supports and encourages the National Institute of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women, and sex and gender minorities in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. (Amend HOD Policy) |
| E | CSAPH 05 | n/a | Biosimilar/Interchangeable Terminology | The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:  1. That Policy H-125.976, “Biosimilar Interchangeability Pathway” be rescinded. (Rescind HOD Policy) 2. That our AMA encourage the FDA to continually collect data and critically evaluate biosimilar utilization including the appropriateness of the term “interchangeable” in regulatory activities. (Directive to Take Action) 3. That Policy D-125.989 “Substitution of Biosimilar Medicines and Related Medical Products” be amended by addition and deletion to read as follows: Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of ~~an interchangeable~~ a biologic or biosimilar product; (3) ~~limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA.~~ in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product. (Modify Current HOD Policy) 4. That Policy D-125.987, “Biosimilar Product Naming and Labeling” be reaffirmed. (Reaffirm HOD Policy) |
| E | CSAPH 07 | n/a | Androgen Deprivation in Incarceration | The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:  1. That Policy H-430.977, “AMA Study of Chemical Castration in Incarceration” be rescinded. (Rescind HOD Policy)  2. That our AMA:  a. Opposes laws, regulations, and actions of the court which remove physician autonomy and clinical judgement from treatment decisions regarding androgen deprivation (also known as chemical castration) for those convicted of sexual crimes.  b. Opposes linkages of criminal sentencing, parole, or probation to court-mandated androgen deprivation. c. Encourages data collection on the utilization, court mandates, duration of therapy, and clinical outcomes of androgen deprivation in the carceral setting. d. Supports continued research for effective treatments for paraphilic disorders, including efforts to reduce stigma and recruit patients with paraphilic disorders into clinical trials. (New HOD Policy)  3. That Policies D-430.997, “Support for Health Care Services to Incarcerated Persons,” H-430.978 “Improving Care to Lower the Rate of Recidivism,” and H-345.981 “Access to Mental Health Services” be reaffirmed. (Reaffirm HOD Policy) |
| E | CSAPH 08 | n/a | Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:   1. That policy D-270.983, “Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing,” be amended by addition to read as follows:   A. Our AMA will ask the FDA to review the available evidence and other data on testosterone and submit updated recommendations, if warranted, to the DEA, for its consideration of the scheduling of testosterone-containing drug products.  B. Our AMA supports policies to remove barriers that delay or impede patient access to prescribed testosterone. (New HOD Policy)   C. Our AMA will continue to work alongside our partner organizations to promote advocacy and physician education on testosterone prescribing. (New HOD Policy)  2. That Policies H-65.976, “Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations,” H-140.824, “Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population,” H-160.991, “Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations,” H-185.927 “Clarification of Evidence-Based Gender-Affirming Care,” H-95.946, “Prescription Drug Monitoring Program Confidentiality,” H-315.983, “Patient Privacy and Confidentiality,” D-185.981, “Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act,” and D-480.964, “Established Patient Relationships and Telemedicine” be reaffirmed. (Reaffirm HOD Policy) |
| E | CSAPH 12 | n/a | Universal Screening for Substance Use and Substance Use Disorders during Pregnancy | The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:  1. That our AMA:   A. Encourage ongoing research on the benefits and risks of universal screening for substance use during pregnancy including the impact of mandatory reporting laws, evaluation of patient outcomes, effectiveness across different age groups, optimal screening intervals, equity considerations, and efficacy of different screening tools.   B. Support the development and dissemination of physician education and training on federal and state laws governing mandatory notification and reporting of substance use during pregnancy, and the benefits and consequences of screening implementation in health care settings on a state-by-state basis. (New HOD Policy)  2. That AMA policy H-420.950, “Substance Use Disorders During Pregnancy,” be amended by addition and deletion to read as follows:  Our AMA will:   (1) support brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions;  (2) acknowledges the health benefits of identifying substance use during pregnancy and opposes any efforts, including mandatory reporting laws, that ~~to~~ imply ~~that~~ a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse or neglect; (3) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (4) oppose the filing of a child protective services report or the removal of infants from their ~~mothers~~ parent(s) solely based on a ~~single positive~~ prenatal drug screen and/or biological test(s) for substance use without appropriate evaluation; (5) 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 or confirmed; and (6) advocate that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, or diagnosis of a substance use disorder, or use of evidence-based treatments for substance use disorder. (Modify Current HOD Policy)  3. That current AMA policies H-420.969, “Legal Interventions During Pregnancy,” and D-95.983, “Mandatory Drug Screening Reporting” be reaffirmed. (Reaffirm HOD Policy) |
| E | Res. 501 | Medical Student Section | Fragrance Regulation | RESOLVED, that our American Medical Association recognize fragrance sensitivity as a disability where the presence of fragranced products can limit accessibility of healthcare settings (New HOD Policy)  RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind (New HOD Policy)  RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care (Directive to Take Action)  RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization in the use of a “fragrance free” designation (Directive to Take Action)  RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one’s body. (New HOD Policy) |
| E | Res. 502 | Medical Student Section | Tribally-Directed Precision Medicine Research | RESOLVED, that our American Medical Association support clinical funding supplements to the National Institutes of Health, the U.S. Food and Drug Administration, and the Indian Health Service to promote greater participation of the Indian Health Service, Tribal, and Urban Indian Health Programs in clinical research. (Directive to Take Action) |
| E | Res. 503 | Hsu, Albert L. MD | Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs) | RESOLVED, that our American Medical Association work with other interested organizations to increase public awareness and promote education on the dangers of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (Directive to Take Action)  RESOLVED, that our AMA work with other interested organizations to advocate to close the loophole in the 2018 Farm bill that allows Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to be regulated as hemp (Directive to Take Action)  RESOLVED, that our AMA work with other interested organizations to advocate for prohibition of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (unless and until properly tested in humans) (Directive to Take Action)  RESOLVED, that our AMA work with other interested organizations to advocate for further research on the health impacts of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, including the potential dangers of these products to children, pregnant women and other vulnerable populations (Directive to Take Action)  RESOLVED, that our AMA report back on this issue at A-25. (Directive to Take Action) |
| E | Res. 504 | California | FDA Regulation of Biosimilars | RESOLVED, that our American Medical Association recognize that, by definition, Biosimilar medications are clinically equivalent to their reference Biologic and therefore do not need a designation of “interchangeability;” (New HOD Policy)  RESOLVED, that our AMA support a rigorous approval process for Biosimilar medications and oppose the application of the redundant designation of “interchangeability” with the reference biologic drug (New HOD Policy)  RESOLVED, that AMA support the development of a model and a process for biologic and biosimilar medication prescribing that protects physician decision-making when a pharmacy-level substitution is not clinically appropriate (New HOD Policy)  RESOLVED, that our AMA support physician education on the clinical equivalence of Biosimilars, the FDA approval process and the post-market surveillance that is required. (New HOD Policy) |
| E | Res. 505 | Medical Student Section | Mitigating the Harms of Colorism and Skin Bleaching Agents | RESOLVED, that our American Medical Association support efforts to reduce the unsupervised use of skin lightening agents, especially due to colorism or social stigma, that do not limit evidence-based use by qualified clinicians (New HOD Policy)  RESOLVED, that our AMA work with the World Medical Association and other interested parties to mitigate the harms of colorism and unsupervised use of skin lightening agents. (Directive to Take Action) |
| E | Res. 506 | Medical Student Section | Screening for Image Manipulation in Research Publications | RESOLVED, that our American Medical Association support the creation of a nationally collaborative database of manipulated images from retracted publications to provide a test bank for researchers developing augmented intelligence-integrated image screening tools. (New HOD Policy) |
| E | Res. 507 | Illinois | Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies | RESOLVED, that our American Medical Association support a permanent ban on medical cannabis companies (and its related holding conglomerates) from owning, investing in, distributing, or promoting recreational (or “adult use”) cannabis or any other activity relating to recreational use of cannabis. (New HOD Policy) |
| E | Res. 508 | Mississippi | AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis | RESOLVED, that our American Medical Association work with the Food and Drug Administration to strengthen how marijuana manufacturers can advertise their products, including regulations that ensure the packaging does not appeal to children (Directive to Take Action)  RESOLVED, that our AMA propose public awareness campaigns aimed at informing the general population, especially parents and guardians, about the risks associated with edible cannabis and the importance of safe storage and handling (Directive to Take Action)  RESOLVED, that our AMA emphasize the importance of childproof packaging for all cannabis products, along with advocating for stricter regulations to enforce this requirement. (New HOD Policy) |
| E | Res. 509 | Senior Physicians Section | Addressing Sarcopenia and its Impact on Quality of Life | RESOLVED, that our American Medical Association collaborate with appropriate entities to develop and implement educational awareness targeting healthcare professionals, caregivers, and the elderly population to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice with elderly patients (Directive to Take Action)  RESOLVED, that our AMA (1) support nutritional interventions aimed at optimizing protein intake, essential amino acids, and micronutrients; (2) promote regular physical activity, including resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities and preferences (New HOD Policy)  RRESOLVED, that our AMA support allocation of resources for research initiatives aimed at advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment modalities (New HOD Policy);  RESOLVED, that our AMA advocate for policy changes to support reimbursement for sarcopenia screening, diagnosis, and interventions (Directive to Take Action)  RESOLVED, that our AMA collaborate with all stakeholders to integrate sarcopenia prevention and management into public health agendas and aging-related initiatives. (Directive to Take Action) |
| E | Res. 510 | New Jersey | Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures” | RESOLVED, that our American Medical Association study the growing problem of advertisements on OTC Vitamins, Supplements, and “Natural Cures” that claim health benefits and cures. With report back at A-25 (Directive to Take Action)  RESOLVED, that our AMA collaborate with all the specialties which are affected by these claims and gather scientific evidence showing benefits and false claims (Directive to Take Action)  RESOLVED, that our AMA request that the FDA exercise its full scope of authority to protect our patients by removing all the advertisements containing false claims of medical cures. (Directive to Take Action) |
| E | Res. 511 | New England | National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling | RESOLVED, that National Penicillin Allergy Day, September 28, be recognized by the American Medical Association (New HOD Policy)  RESOLVED, that our AMA promote penicillin allergy evaluation and appropriate delabeling. (New HOD Policy) |
| E | Res. 512 | New York | Opioid Overdose Reversal Agents Where AED’s Are Located | RESOLVED, that our American Medical Association support the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations. (New HOD Policy) |
| E | Res. 513 | New York | Biotin Supplement Packaging Disclaimer | RESOLVED, that our American Medical Association support efforts to have over-the-counter biotin supplements provide a clear disclaimer on the bottle that states the possibility of lab test interference (New HOD Policy)  RESOLVED, that our AMA advocates for greater awareness among both patients and physicians in regards to biotin megadose interference. (Directive to Take Action) |
| F | BOT 04 | n/a | AMA 2025 Dues | The Board of Trustees recommends no change to the dues levels for 2024, that the following be adopted and that the remainder of this report be filed: Regular Members $ 420 Physicians in Their Fourth Year of Practice $ 315 Physicians in Their Third year of Practice $ 210 Physicians in Their Second Year of Practice $ 105 Physicians in Their First Year of Practice $ 60 Physicians in Military Service $ 280 Semi-Retired Physicians $ 210 Fully Retired Physicians $ 84 Physicians in Residency/Fellow Training $ 45 Medical Students $ 20 (Directive to Take Action) |
| F | BOT 21 | n/a | American Medical Association Meeting Venues and Accessibility | The Board therefore recommends Policy G-630.140 be reaffirmed and is strictly enforced as a resolute stance against all forms of discrimination, and support of evidenced-based medicine, underscoring our commitment to fostering an inclusive and safe environment for all attendees. This strategic recommendation places a primary emphasis on prioritizing attendee safety, reflecting the values and principles upheld by the AMA |
| F | BOT 23 | n/a | United States Professional Association for Transgender Health Observer Status in the House of Delegates | The Board of Trustees recommends that the United States Professional Association for Transgender Health be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed. |
| F | BOT 25 | n/a | Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences | RECOMMENDATION: The Board of Trustees recommends that the following be adopted in lieu of Resolutions 603-A-23 and 608-A-23, and the remainder of the report be filed: 1. Our AMA is committed to progression to net zero emissions for its business operations by 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and the transition to renewable energy sources (New HOD Policy). 2. Our AMA will prioritize sustainable organizational practices to reduce emissions over purchasing carbon offsets (New HOD Policy). 3. Our AMA will continue to prioritize collaboration within the health care community by sharing the learnings from our sustainability initiative to inspire our peer organizations to follow suit and adopt similar environmentally conscious practices (Directive-to-Take-Action) |
| F | BOT 26 | n/a | Equity and Justice Initiatives for International Medical Graduates | The Board of Trustees recommends that Resolution 605-A-23 not be adopted and that the remainder of this report be filed. |
| F | BOT 28 | n/a | Encouraging Collaboration Between Physicians and Industry in AI Development | The Board of Trustees recommends that Resolution 609-A-23 not be adopted and that this report be filed. |
| F | BOT 33 | n/a | Employed Physicians | The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:  1. That AMA policy D-405.969 be rescinded as having been accomplished by this report (Rescind HOD Policy) |
| F | CCB/CLRPD 01 | na | Joint Council Sunset Review of 2014 House Policies | The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. |
| F | CLRPD 01 |  | Establishment of a LGBTQ+ Section | The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That our American Medical Association transition the Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) Issues to the LGBTQ+ Section as a delineated section. (Directive to Take Action) 2. That our AMA develop bylaw language to recognize the LGBTQ+ Section. (Directive to Take Action) |
| F | Comp Rep 01 | na | Compensation Committee Report | The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report be filed:  1. That the secretarial reimbursement be increased to $1,125 effective January 1, 2025. 2. That there be no changes to Officers’ compensation for the period beginning July 1, 2024 through June 30, 2025. 3. That the remainder of the report be filed. |
| F | Res. 601 | Medical Student Section | Annual Holocaust Remembrance Event | RESOLVED, that our American Medical Association 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. (Directive to Take Action) |
| F | Res. 602 | Young Physicians Section | Ranked Choice Voting | RESOLVED, that our American Medical Association study ranked-choice voting for all elections within the House of Delegates. (Directive to Take Action) |
| F | Res. 603 | Resident and Fellow Section | End Attacks on Health and Human Rights in Israel and Palestine | RESOLVED, that our American Medical Association supports a ceasefire in Israel and Palestine in order to protect civilian lives and healthcare personnel. (New HOD Policy) |
| F | Res. 604 | Senior Physicians Section | Confronting Ageism in Medicine | RESOLVED, that our American Medical Association adopt the following definition of ageism based on the World Health Organization (WHO) and AGE Platform Europe: “Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age; structural ageism is the way in which society and its institutions sustain ageist attitudes, actions or language in laws, policies, practices or culture” (New HOD Policy);   RESOLVED, that our AMA establish a definition of “age equity,” and consider adoption of the AGE Platform Europe vision: “Age equity is an inclusive society, based on well-being for all, solidarity between generations and full entitlement to enjoy life, participate in and contribute to society. At the same time, each person’s rights and responsibilities throughout their life course have to be fully respected” (Directive to Take Action);   RESOLVED, that our AMA review all existing policy regarding discrimination, bias and microaggressions, and add age or ageism if not already mentioned (Directive to Take Action)  RESOLVED, that our AMA routinely incorporate intersectional approaches to ageism (Directive to Take Action)  RESOLVED, that our AMA conduct ongoing (1) advocacy for hospital and regulatory policy changes focused on individual physicians’ care quality data rather than their age; and (2) educational outreach to AMA members (i.e. starting with a Prioritizing Equity episode panel discussion to be posted on Ed HubTM for CME, as a video and podcast, and promoted through the UCEP/GCEP channels) (Directive to Take Action)  RESOLVED, that our AMA work with the World Medical Association (WMA) and other interested stakeholders to have AMA’s work significantly inform the global health organization's work on ageism. (Directive to Take Action) |
| F | Res. 605 | Senior Physicians Section | Walking the Walk of Climate Change | RESOLVED, that our American Medical Association Board of Trustees present to the House of Delegates at Interim 2024 a detailed timeline as to when and how to achieve our organizational carbon neutrality (Directive to Take Action)  RESOLVED, that our AMA staff study AMA-related corporate travel with respect to minimizing carbon emissions and/or mitigating or off-setting such emissions (Directive to Take Action)  RESOLVED, that our AMA adopt a policy for plant-based menus as the default option when planning meeting venues with an opt-out alternative as appropriate. (Directive to Take Action) |
| F | Res. 606 | New England | Creation of an AMA Council with a Focus on Digital Health Technologies and AI | RESOLVED, that our American Medical Association define and propose a new AMA council focused on digital health, technology, informatics, and augmented/artificial intelligence, whose members shall be elected by the House of Delegates, for presentation and constitution at the 2025 Annual Meeting. (Directive to Take Action) |
| F | Res. 607 | New Jersey | Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health | RESOLVED, that our American Medical Association amends its mission’s statement from “to promote the art and science of medicine and the betterment of public health” to “to empower physicians to better care for their patients, advance the art and science of medicine, and promote the betterment of physicians and the public health”. (Directive to Take Action) |
| F | Res. 608 | Minority Affairs Section | The American Medical Association Diversity Mentorship Program | RESOLVED, that our American Medical Association establish a diversity mentorship program to connect volunteer mentors with residents, fellows, and medical student mentees who are underrepresented in medicine. (Directive to Take Action) |
| F | Speakers' 01 |  | Report of the Resolution Modernization Task Force Update | The Resolution Modification Task Force recommends that the following be adopted to be implemented for Interim 2024 and the remainder of the report be filed:   1. The bylaws be amended so that the resolution submission deadline be 45 days prior to the opening session of the House of Delegates. (Directive to take Action) 2. The bylaws be amended so that the definition of a late resolution shall be all resolutions submitted after the resolution submission deadline and prior to the beginning of the Opening Session of the House of Delegates. (Directive to take Action) 3. The bylaws be amended so that the definition of an emergency resolution shall be all resolutions submitted after the beginning of the Opening Session of the House of Delegates. (Directive to take Action) 4. The bylaws be amended so that the term of committees of the House of Delegates shall commence upon their formation and shall conclude at the end of the meeting for which they were appointed, unless otherwise directed by the House of Delegates. (Directive to take Action) 5. That our AMA will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days. This shall be accomplished in lieu of Policy G-600.045. (New HOD Policy) 6. Prior to House of Delegates meetings, reference committees will convene after the close of the Online Reference Committee Hearings to develop a Preliminary Reference Committee Report. These reports shall include preliminary recommendations and will serve as the agenda for the in-person reference committee hearing. This shall be accomplished in lieu of Policy G-600.060(8). (New HOD Policy) 7. That Policy D-600.956 be rescinded. (Rescind HOD Policy) |
| G | BOT 29 | n/a | Transparency and Accountability of Hospitals and Hospital Systems | The Board of Trustees recommends: 1. The following policies be reaffirmed:  a.Policy H-405.950, “Preserving the Practice of Medicine”  b. Policy H-225.950, “Principles for Physician Employment”  c. Policy H-225.952, “The Physician’s Right to Exercise Independent Judgement in All Organized Medical Staff Affairs”  d. Policy H-230.965, “Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators”  e. Policy H-435.942, “Fair Process for Employed Physicians”  f. Policy H-375.962, “Legal Protections for Peer Review  g. Policy D-375.987, “Effective Peer Review”  h. Policy H-375.960, “Protection Against External Peer Review Abuses” (Reaffirm HOD policy); and 2. That the following policy statement be adopted to supersede Policy H-200.971, “Transparency and Accountability of Hospitals and Hospital Systems,”:  a. The AMA supports transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports (New HOD Policy).  b. The AMA will develop educational materials on the peer review process, including information about what constitutes a bad-faith peer review and what options physicians may have in navigating the peer review process (Directive to Take Action). 3. That the title of Policy H-200.971, “Transparency and Accountability of Hospitals and Hospital Systems,” be changed to:  a. “Transparent Reporting of Physician Complaints Against Hospitals and Health Systems” 4. That the remainder of this report be filed. |
| G | BOT 30 | n/a | Proper Use of Overseas Virtual Assistants in Medical Practice | The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed:  1. That our American Medical Association (AMA) reaffirm the following policies:  a. H-385.951- Remuneration for Physician Services  b. H-180.944 - Plan for Continued Progress Toward Health Equity   c. H-135.932 - Light Pollution: Adverse Health Effects of Nighttime Lighting; (Reaffirm HOD Policy) and  2. That Policy H-200.947 be amended to read as follows: “Our AMA: (1) supports the concept that properly trained ~~overseas~~ virtual assistants, in the U.S. or overseas, are an acceptable way to staff administrative roles in medical practices; and (2) will ~~study and offer formal guidance for physicians on how best to utilize overseas virtual assistants to ensure protection of patients, physicians, practices, and equitable employment in communities served, in a manner consistent with appropriate compliance standards~~ create and publish educational materials for medical practices that offer formal guidance on how best to utilize virtual assistants to ensure protection of patients, physicians, virtual assistants and practices.” (Modify Current HOD Policy). |
| G | CMS 01 | n/a | Council on Medical Service Sunset Review of 2014 House Policies | The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed (Directive to Take Action) |
| G | CMS 05 | n/a | Patient Medical Debt | The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 710-A-23 and Resolution 712-A-23, and the remainder of the report be filed:   1) That our American Medical Association (AMA) encourage health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions. (New HOD Policy) 2) That our AMA supports innovative efforts to address medical debt for patients, including public and private efforts to eliminate medical debt. (New HOD Policy) 3) That our AMA support amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection. (New HOD Policy)  4) That our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing. (New HOD Policy) 5) That our AMA support patient education on medical debt that addresses dimensions such as:   a. Patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;   b. The ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician’s office, or other non-physician provider’s office;   c. Potential financial aid available from a patient’s hospital and/or physician’s office; and   d. Methods to reduce high deductibles and cost-sharing. (New HOD Policy) |
| G | CMS 06 | n/a | Economics of Prescription Medication Prior Authorization | The Council on Medical Service recommends that the following be adopted in lieu of Resolution 725-A-23, and the remainder of the report be filed:  1. That our American Medical Association (AMA) support working with payers and interested parties to ensure that prior authorization denial letters include at a minimum (1) a detailed explanation of the denial reasoning, (2) a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial, and (3) what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication. (New HOD Policy)   2. That our AMA amend Policy H-120.919 to read as follows: That our AMA will: (1) continue to support efforts to ~~publish~~ implement a ~~Real-Time Prescription Benefit (RTPB)~~ Real-Time Benefit Tool (RTBT) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) support efforts to ensure that provider-facing and patient facing RTBT systems align; and (3) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an ~~RTPB~~ RTBT standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish ~~RTPB~~ RTBT tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; (4) advocate that RTBT systems provide a justification for why prior authorization is required and include approved/covered alternative prescription medications; ~~and~~ (~~3~~5) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize ~~RTPB tools~~ RTBT and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment; (6) advocate that payers honor coverage information that is based on a RTBT at the time of prescription and that prior authorization approvals should be valid for the duration of the prescribed/ordered treatment; and (7) continue to advocate for the accuracy and reliability of data provided by RTBTs and for vendor neutrality to ensure that it is supportive to physician efforts. (Modify Current HOD Policy)  3. That our AMA reaffirm Policy H-110.963, which addresses the regulation and monitoring of third-party Pharmacy Benefit Managers (PBMs) in an effort to control prescription drug pricing. (Reaffirm HOD Policy)  4. That our AMA reaffirm Policy H-125.979, which outlines advocacy efforts to ensure that physicians have access to real-time formulary data when prescribing. (Reaffirm HOD Policy)  5. That our AMA reaffirm Policy H-320.945, which details opposition to the abuse of prior authorization and the requirement for payers to accurately report denials and approvals. (Reaffirm HOD Policy)  6. That our AMA reaffirm Policy H-125.986, which outlines the AMA’s position that certain actions from PBMs interfere with physician practice and may impact the patient-physician relationship. (Reaffirm HOD Policy)  7. That our AMA reaffirm Policy D-120.933, which encourages the gathering of data to better understand the impact that PBM actions may lead to an erosion of the patient-physician relationship. (Reaffirm HOD Policy) |
| G | Res. 701 | Medical Student Section | Opposition to the Hospital Readmissions Reduction Program | RESOLVED, that our American Medical Association oppose the Hospital Readmissions Reduction Program. (New HOD Policy) |
| G | Res. 702 | Organized Medical Staff Section | The Corporate Practice of Medicine, Revisited | RESOLVED, that our American Medical Association revisit the concept of restrictions on the corporate practice of medicine, including private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report to our House of Delegates by Annual 2025 that will inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality healthcare, while containing healthcare costs. (Directive to Take Action) |
| G | Res. 703 | Resident and Fellow Section | Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation | RESOLVED, that our American Medical Association advocates for transparency, accountability, and fair pricing practices in pharmaceutical pricing, opposing differential pricing of medications manufactured by the same company with the same active ingredient, without clear clinical necessity (Directive to Take Action)  RESOLVED, that our AMA condemns interference with a physician’s ability to prescribe one medication over another with the same active ingredient, without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices. (New HOD Policy) |
| G | Res. 704 | American Academy of Pediatrics | Pediatric Readiness in Emergency Departments | RESOLVED, that our American Medical Association reaffirm H-130.939 acknowledging the importance of pediatric readiness in all emergency departments with awareness of the guidelines for Pediatric Readiness in the Emergency Department and stand ready to care for children of all ages (Reaffirm HOD Policy)  RESOLVED, that our AMA work with appropriate state and national organizations to advocate for the development and implementation of regional and/or state pediatric-ready facility recognition programs. (Directive to Take Action) |
| G | Res. 705 | Illinois | 20 Minute Primary Care Visits | RESOLVED, that our American Medical Association ask that the appropriate AMA Council conduct a study of the adverse effects of direct patient care time limitations on the quality of care provided, as well as on patient and physician dissatisfaction, with a report back at the next AMA Annual Meeting. (Directive to Take Action) |
| G | Res. 706 | Association for Clinical Oncology | Automatic Pharmacy-Generated Prescription Requests | RESOLVED, that our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient’s surrogates, or automatically by the pharmacy. (Directive to Take Action) |
| G | Res. 707 | Association for Clinical Oncology | Alternative Funding Programs | RESOLVED, that our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs. (Directive to Take Action) |
| G | Res. 708 | National Association of Medical Examiners | Medicolegal Death Investigations | RESOLVED, that our American Medical Association supports the independent authority of physicians practicing forensic pathology to provide accurate and transparent postmortem assessments and death investigation reporting in a manner free from undue influence (New HOD Policy)  RESOLVED, that our AMA advocate with state and federal governments to ensure laws and regulations do not compromise a physician’s ability to use their medical judgement in the reporting of postmortem assessments and medicolegal death investigations. (Directive to Take Action) |
| G | Res. 709 | American College of Emergency Physicians | Improvements to Patient Flow in the U.S. Healthcare System | RESOLVED, that our American Medical Association work with relevant stakeholders and propose recommendations to appropriate entities to improve patient flow and access to care throughout multiple environments in the U.S. healthcare system. (Directive to Take Action) |
| G | Res. 710 | American College of Emergency Physicians | The Regulation of Private Equity in the Healthcare Sector | RESOLVED, that our American Medical Association propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy in clinical care is preserved and protected (Directive to Take Action)  RESOLVED, that our AMA modify policy H-215.981, Corporate Practice of Medicine, by addition:  4. Our AMA will work with the federal government and other interested parties to develop and advocate for regulations pertaining to the use of private equity in the healthcare sector such that physician autonomy in clinical care is preserved and protected. (Modify Current HOD Policy) |
| G | Res. 711 | Ohio | Insurer Accountability When Prior Authorization Harms Patients | RESOLVED, that our American Medical Association advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts. (Directive to Take Action) |
| G | Res. 712 | New York | Full transparency - Explanation of Benefits | RESOLVED, that our American Medical Association will advocate legislation and regulations that mandate that explanation of benefits, whether sent to the patient or the physician practice, including the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints. (Directive to Take Action) |
| G | Res. 713 | New York | Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums | RESOLVED, that our American Medical Association will advocate for legislation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, or electronic transaction, including but not limited to X12 270/271 (Directive to Take Action)  RESOLVED, that our AMA will advocate for legislation or regulation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, electronic transaction including but not limited to X12 270/271 (Directive to Take Action)  RESOLVED, that our AMA will advocate that X12 includes plan premium payment status as part of X12 270/271 standard transaction code updates (Directive to Take Action)  RESOLVED, that our AMA will report on the status of this resolution at the 2025 Annual Meeting. (Directive to Take Action) |