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ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Annual 2024 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations key
Instructions for the delegate and alternate delegate are designated as follows:
- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Monitor* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the OMSS
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Items for consideration by the Assembly
The Governing Council recommends that the following items be considered by the Organized Medical Staff Section as items of interest to the Section and instructs the Delegate and Alternate Delegate to take prescribed action.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	.CON	CCB 03 – 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Council on Constitution and Bylaws recommends that the following recommendations be adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed. 1) That our AMA Bylaws be amended by insertion to add the following provisions.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	Delegate instructed to support (2) and (3) and seek amendment on (1) to establish a sense of due process.

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			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)	
2	.CON	CEJA 02 – 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	Delegate instructed to support.

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			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;	

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			(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	

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			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.	

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			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. <u>(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.</u> (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	

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			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)	

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			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.	
3	.CON	CEJA 03 – 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~~	Delegate instructed to support.

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			~~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	

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			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)	
4	.CON	Res. 001 – Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout (Integrated Physician Practice Section)	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)	Delegate instructed to support.

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5	.CON	Res. 002 – Removal of the Interim Meeting Resolution Committee (Medical Student Section, Resident & Fellow Section)	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~~	Delegate instructed to strongly oppose.

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			~~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)	
6	.CON	Res. 008 – Consolidated Health Care Market (Barbara L. McAneny, MD)	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)	Delegate instructed to strongly support.
7	.CON	Res. 014 – The Preservation of the Primary Care Relationship (New England)	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)	Delegate instructed to support.
8	.CON	Res. 018 – 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, age, or other factor (New HOD Policy);	Delegate instructed to amend as indicated.

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		(New York)	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)	
9	A	CMS 08 – 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~~	Delegate instructed to support.

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			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	

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			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)	
10	B	BOT 13 – 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)	Delegate instructed to support.
11	B	BOT 14 – 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	Delegate instructed to strongly support.

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			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)	
12	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 1 of 4	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	Delegate instructed to support, but seek inclusion of language acknowledging that medical staff ought to be a key part of implementation of AI in any care facility.

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			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)]	
13	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 2 of 4	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	See Item 12.

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			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.	
14	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 3 of 4	• 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	See Item 12.

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			•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	
15	B	BOT 15 – Augmented Intelligence Development, Deployment, and Use in Health Care 4 of 4	• 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]	See Item 12.
16	B	Res. 204 – Staffing Ratios in the Emergency Department (Florida)	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)	Delegate instructed to support Resolve 1, refer Resolve 2 (Pending I-24 report).

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17	B	Res. 210 – Support for Physicians Pursuing Collective Bargaining and Unionization (Oregon, American College of Physicians)	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)	Delegate instructed to refer until CEJA report at I-24.
18	B	Res. 211 – Deceptive Hospital Badging 2.0 (Organized Medical Staff Section)	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)	Delegate instructed to support.
19	B	Res. 212 – Advocacy Education Towards a Sustainable Medical Care System (Organized Medical Staff Section)	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)	Delegate instructed to support.
20	B	Res. 213 – Access to Covered Benefits with an Out of Network Ordering Physician (Private Practice Physicians Section)	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)	Delegate instructed to support.

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			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)	
21	B	Res. 228 – Waiver of Due Process (Missouri)	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)	Delegate instructed to support.
22	B	Res. 235 – Establish a Cyber-Security Relief Fund (New Jersey)	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)	Delegate instructed to strongly support.
23	B	Res. 236 – Support of Physicians Pursuing Collective Bargaining and Unionization (Delaware)	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)	Delegate instructed to Refer until CEJA report at I-24.
24	C	Res. 302 – 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	Delegate instructed to support, strongly support Resolve 3.

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		(Private Practice Physicians Section)	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)	
25	C	Res. 316 – Reassessment of Continuing Board Certification Process (New England)	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)	Delegate instructed to support.
26	D	Res. 427 – Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals (New England)	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	Delegate instructed to seek report back.

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			shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians. (Directive to Take Action)	
27	F	BOT 21 – 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	Delegate instructed to support for reaffirmation.
28	F	BOT 33 – 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)	Delegate instructed to support.
29	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	Delegate instructed to support Resolve 6, refer all else.

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			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)	
30	F	Res. 602 – Ranked Choice Voting (Young Physicians Section)	RESOLVED, that our American Medical Association study ranked-choice voting for all elections within the House of Delegates. (Directive to Take Action)	Delegate instructed to oppose.
31	F	Res. 604 – Confronting Ageism in Medicine (Senior Physicians Section)	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)	Delegate instructed to support.

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			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)	
32	F	Res. 606 – Creation of an AMA Council with a Focus on Digital Health Technologies and AI (New England)	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)	GC seeks OMSS General Assembly input.
33	F	Res. 607 – Appealing to our AMA to add clarity to its mission statement to better meet the needs of physicians, the practice of medicine and the public health. (New Jersey)	RESOLVED, That our American Medical Association amends its mission 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).	Delegate instructed to support.
34	G	BOT 29 – Transparency and Accountability of	The Board of Trustees recommends: 1. The following policies be reaffirmed: a.Policy H-405.950, "Preserving the Practice of Medicine"	Delegate instructed to support.

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		Hospitals and Hospital Systems	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.	
35	G	CMS 05 – 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	Delegate instructed to listen.

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			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)	
36	G	Res. 701 – Opposition to the Hospital Readmissions Reduction Program (Medical Student Section)	RESOLVED, that our American Medical Association oppose the Hospital Readmissions Reduction Program. (New HOD Policy)	Delegate instructed to support.

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37	G	Res. 702 – The Corporate Practice of Medicine, Revisited (Organized Medical Staff Section)	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)	Delegate instructed to support.
38	G	Res. 704 – Pediatric Readiness in Emergency Departments (American Academy of Pediatrics)	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)<u>; and be it further</u> <u>RESOLVED, that our AMA recognizes it may be necessary to allow reasonable accommodation from the guidelines for Pediatric Readiness in the Emergency Room in such circumstances where facility location, or focus, limits availability of specialized and subspecialty personnel. In such cases, such limitations should be made public knowledge, particularly informing emergency transport services and civil authorities (New HOD Policy); and be it futher</u> 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)	Delegate instructed to amend as indicated.
39	G	Res. 710 – The Regulation of Private Equity in the Healthcare Sector (American College of Emergency Physicians)	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	Delegate instructed to support.

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			the healthcare sector such that physician autonomy in clinical care is preserved and protected. (Modify Current HOD Policy)	
40	G	Res. 711 – Insurer Accountability When Prior Authorization Harms Patients (Ohio)	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)	Delegate instructed to support.

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Items of interest to the Assembly
The Governing Council identifies the following items as potentially of interest to the Organized Medical Staff Section but does not provide instruction to the Delegate and Alternate Delegate for action.

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1	B	Res. 240 – Expanding Visa Requirement Waivers for IMGs Working in Underserved Areas (New York)	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)
2*	C	Res. 303 – Amend Policy D-275.948 "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 (Young Physicians Section)	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)
3	D	Res. 414 – Addressing the Health Sector's Contributions to the Climate Crisis (California)	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

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			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)
4	D	Res. 415 – 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)

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5	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)
6	Info	BOT 12 – AMA Efforts on Medicare Payment Reform	CONCLUSION As we forge ahead in continued partnership with the Federation to advance organized medicine's collective goals in our strategic mission to reshape the Medicare physician payment system, the AMA remains unwavering in its commitment to successfully pursuing the four pillars discussed in this report. Our steadfast dedication ensures that our members' voices are heard, and that we advocate for a system that is fair, sustainable, and reflective of the value physicians bring to patient care. Facing a nearly percent reduction in Medicare payments over the past four years, physicians are at a breaking point and are struggling to maintain access to care for the Medicare beneficiaries they treat. Rising practice costs, workforce shortages, and financial uncertainty coupled with the continued lack of positive Medicare payment updates is threatening the viability of physician practices. This is unsustainable and unacceptable. While there has been some progress so far in 2024, significant advocacy work remains in the year ahead and beyond to achieve our vision of Medicare physician payment reform.

*OMSS Delegate and Alternate Delegate will reach out to sponsor to discuss outside of official consideration.

END