AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
(Annual 2024)

Report of the Medical Student Section Reference Committee

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Revised 05/22/2024, Item 26

Your Reference Committee recommends the following consent calendar for acceptance:

VIRTUAL EXTRACTIONS ARE DUE BY THU MAY 30, 11:59PM PT

RECOMMENDED FOR ADOPTION

1. Resolution 105 - Native American Medical Debt
2. Resolution 210 - Opposition of the Deceptive Relocation of Migrants and Asylum Seekers
3. Resolution 425 - Support of Universal School Meals for School Age Children
4. Resolution 601 - Advisory Committee on Tribal Affairs
5. GC Report C - Biennial Review of Organizations Seated in the AMA-MSS Assembly
6. GC Report D - MSS Abortion, Contraception, & Sex Education Position Consolidation
7. GC Report E - MSS Employment & Educational Leave Positions Review & Consolidation
8. GC Report F - MSS Firearm Positions Consolidation
9. GC Report G - Review & Consolidation of Positions Relating to MSS Governance
10. GC Report H - MSS Alcohol-Related Positions Consolidation
11. GC Report I - Guidelines for Official Observers in the AMA-MSS Assembly
12. CEQM COLA Report A - Opposing Private Equity Acquisitions of Healthcare Practices
13. SD Report A - MSS Policy Process and HOD Resolution Queue

RECOMMENDED FOR ADOPTION AS AMENDED

14. Resolution 015 - Support of Collective Bargaining
15. Resolution 102 - Radiation Exposure Compensation Coverage
16. Resolution 108 - ACA Subsidies for Undocumented Immigrants
17. Resolution 109 - Tribal Dialysis Access
18. Resolution 115 - Corrections to The Medicare Part C Payment Structure
19. Resolution 205 - Support for Doula Care Programs
20. Resolution 207 - Repatriation of American Indian, Alaska Native, and Native Hawaiian Remains
21. Resolution 211 - SSI Savings Penalty Elimination

22. Resolution 223 - Increased Transparency in Psychotropic Drug Administration in Prisons
23. Resolution 419 - Equity in Celiac Disease and Food Allergies Research and Resources
24. Resolution 422 - Protecting the Healthcare Supply Chain from the Impacts of Climate Change
25. Resolution 427 - AMA Study on Plastic Pollution Reduction
26. GC Report A – Sunset Report
27. GC Report J - Use of Inclusive Language in AMA Policy
28. CEQM WIM LGBTQ+ Report - Coverage for Care Provided After Sexual Assault
29. LGBTQ+ CHIT Report - Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
30. MIC CSI CAIA - Increasing Access to Medical Interpreters in Research and Support for Increased Diversity in Genetic Research
31. ATF Report – MSS Archives Task Force Report
32. SCTF Report – MSS Standing Committee Task Force Annual Report

RECOMMENDED FOR ADOPTION IN LIEU OF

33. Resolution 004 - Supporting Community Physician and Paramedic Partnerships
34. Resolution 321 - Humanism in Anatomical Medical Education
35. Resolution 423 - Preventing Heat Related Illness with Appropriate Heat Response Standards

RECOMMENDED FOR NOT ADOPTION

36. Resolution 008 - Routine Provision of Information Concerning Insulin Cost-Reduction Programs
37. Resolution 020 - Support for Early Detection and Intervention of Juvenile Depression
38. Resolution 021 - Physician-led and Rural Access to Emergency Care
39. Resolution 022 - Opposition to Capital Punishment
40. Resolution 023 - Improving IPV Screening for People with Disabilities
41. Resolution 203 - Access to Healthcare for Transgender and Gender Diverse Incarcerated People
42. Resolution 213 - Undocumented Worker Protections
43. Resolution 308 - Expanding Medical Education Access and Support for First-Generation Students
44. Resolution 311 - Parity for DO and MD Graduating Seniors through Reporting Total Number of DO and MD Applicants Interviewed and Ranked by Each Residency Program
45. Resolution 313 - Opposition to Medical School Admissions Preference for Children of Donors and Faculty

46. Resolution 315 - Removing Headshot Requirements from Medical School, Residency, and Fellowship Applications
47. Resolution 402 - Studying the Effects of Plant-Based Meat
48. Resolution 403 - Improving Child Disciplinary Education for Caregivers
49. Resolution 404 - Support for Standardized Periodic Hearing Screenings in Primary Schools
50. CME CDA Report A - Studying Effects of Online Education on Medical Education Outcomes During Covid-19 Pandemic
51. WIM COLA LGBTQ+ Report - Addressing Gender-Based Disparities on Health-Related Consumer Goods (The Pink Tax)

RECOMMENDED FOR FILING

52. GC Report B – MSSAI Report
53. SD Report B - Policy Proceedings of the Interim 2023 House of Delegates Meeting

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 105 - NATIVE AMERICAN MEDICAL DEBT

RECOMMENDATION:

Resolution 105 be <u>adopted</u>.

RESOLVED, that our American Medical Association support federal legislation requiring credit reporting agencies to remove information on the credit reports of Indian Health Service (IHS) beneficiaries that relate to debts or collections activities for medical services that should have been paid by the IHS.

VRC testimony was supportive of the resolution. Your Reference Committee agrees with testimony that the resolution is novel, has a strong evidence base, and is timely, given recent efforts in the House of Representatives to amend the Fair Credit Reporting Act. Your Reference Committee recommends Resolution 105 be adopted.

(2) RESOLUTION 210 - OPPOSITION OF THE DECEPTIVE RELOCATION OF MIGRANTS AND ASYLUM SEEKERS

RECOMMENDATION:

Resolution 210 be <u>adopted</u>.

RESOLVED, that our American Medical Association oppose the relocation of migrants and asylum-seekers by state or federal authorities without timely and appropriate resources to meet travelers' needs, especially when deceptive or coercive practices are used; and be it further

RESOLVED, that our AMA support state and federal efforts to protect the health and safety of traveling migrants and asylum-seekers and investigate possible abuse and human rights violations.

VRC testimony was supportive of the resolution. Your Reference Committee agrees with testimony that the resolution is novel and well-supported. Your Reference Committee recommends Resolution 210 be adopted.

(3) RESOLUTION 425 - SUPPORT OF UNIVERSAL SCHOOL MEALS FOR SCHOOL AGE CHILDREN

RECOMMENDATION:

Resolution 425 be <u>adopted</u>.

RESOLVED, that our American Medical Association advocate for federal and state efforts to adopt, fund, and implement universal school meal programs that include the provision of breakfast and lunch to all school-aged children, free of charge to families, regardless of income.

VRC testimony was very supportive. Your Reference Committee agrees with testimony that this resolution is novel and has a strong evidence base. Your Reference Committee recommends Resolution 425 be adopted.

(4) RESOLUTION 601 - ADVISORY COMMITTEE ON TRIBAL AFFAIRS

RECOMMENDATION:

Resolution 601 be <u>adopted</u>.

RESOLVED, that our American Medical Association: (1) establish an Advisory Committee on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN) or have direct experience or close professional relationships with AI/AN communities (e.g., members of ANAMS and AAIP) or the Indian Health Service to advise the Board of Trustees on how to implement policy specific to AI/AN communities; and (2) promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

VRC testimony was very supportive. Your Reference Committee agrees with testimony that this resolution is important and that an AI/AN Advisory Council will help our AMA take appropriate action for policies regarding this population. We agree with testimony that this resolution is novel and feasible. Your Reference Committee recommends Resolution 601 be adopted.

(5) GC REPORT C - BIENNIAL REVIEW OF ORGANIZATIONS SEATED IN THE AMA-MSS ASSEMBLY

RECOMMENDATION:

GC Report C be <u>adopted</u>.

Thus, your MSS Governing Council recommends that the following recommendations be <u>adopted</u> and the remainder of this report be filed:

1. That our AMA-MSS retains the following NMSSs and PIMAs as eligible for AMA-MSS Assembly representation: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP),, American College of Emergency Physicians (ACEP), American College of Medical Quality (ACMQ), American College of Physicians (ACP), American Society of Anesthesiologists (ASA),American Medical Women's Association (AMWA), Student Osteopathic Medical Association (SOMA), Psychiatry Student Interest Group Network (PsychSIGN), and Health Professionals Advancing LGBTA Equality (GLMA).

2. That our AMA-MSS retains the following NMSOs as eligible for AMA-MSS Assembly representation: American Physician Scientists Association (APSA), Asian Pacific American Medical Student Association (APAMSA), Latino Medical Student Association (LMSA), and Student National Medical Association (SNMA), and Association of Native American Medical Students (ANAMS), Medical Student Pride Alliance (MSPA).

3. That our AMA-MSS recognize the following NMSS, NMSO and PIMA organizations as newly seated organizations in the AMA-MSS Assembly:
    a. American Academy of Child & Adolescent Psychiatry (AACAP)
    b. American Academy of Ophthalmology (AAO)
    c. American Academy of Orthopedic Surgeons (AAOS)
    d. ACPM (American College of Preventive Medicine)
    e. ACS (American College of Surgeons)
    f. ASPS (American Society of Plastic Surgeons)
    g. United States Air Force
    h. United States Army
    i. United States Navy

VRC testimony was limited. Your Reference Committee thanks the MSS Governing Council for their review of organizations seated in the MSS Assembly and agrees with their recommendations. Your Reference Committee recommends GC Report C be adopted.

(6) GC REPORT D - MSS ABORTION, CONTRACEPTION, & SEX EDUCATION POSITION CONSOLIDATION

RECOMMENDATION:

GC Report D be <u>adopted</u>.

Thus, your MSS Governing Council recommends that the following recommendations be adopted, the following new consolidated positions be retained as active positions of the AMA-MSS, the original comprising positions be rescinded and the remainder of this report be filed:

RESOLVED, the following MSS Positions:

- 5.001MSS Public Funding of Abortion Services

- 5.002MSS Condemnation of Violence Against Abortion Clinics
- 5.003MSS Patient Confidentiality and Reproductive Health
- 5.005MSS MSS Stance on Challenges to Women's Right to Reproductive Health Care Access
- 5.006MSS Transparency on Restrictions of Care
- 5.007MSS Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone
- 5.008MSS Expanding AMA Support for Advanced Practice Providers who Provide First- Trimester Abortion Care
- 5.009MSS Protecting Access to Abortion and Reproductive Healthcare
- 5.010MSS AMA Opposition of Heartbeat Laws which Indicate First Evidence of Embryonic Cardiac Activity as Presence of Fetal Heartbeat
- 5.011MSS Coverage and Reimbursement for Abortion Services
- 5.012MSS Opposition to Restrictions on United States Foreign Aid Allocation for Reproductive Healthcare
- 75.003MSS Contraceptive Programming in the Media
- 75.005MSS Promotion of Emergency Contraception Pills
- 75.009MSS Ending Discrimination Against Contraception
- 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception
- 75.013MSS Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement
- 75.014MSS Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
- 250.019MSS Global HIV/AIDS Prevention
- 255.004MSS United Nations Population Fund
- 270.056MSS Condemnation of Non-Therapeutic Sterilization for Contraception of Women with
- Disabilities without Informed Patient Consent
- 420.008MSS Advance Directives During Pregnancy
- 420.013MSS Amendment to Truth and Transparency in Pregnancy Counseling Centers
- 420.020MSS Access to Standard Care for Non-Viable Pregnancy
- 525.012MSS Transparency Improving Informed Consent for Reproductive Health Services

be consolidated into the new MSS position:

Abortion and Contraception Access

The AMA MSS asked the AMA to:

(1) Recognize that policies and legislation that limit access to abortion care are serious threats to public health;

(2) Support explicit codification of protections for abortion care into federal law;

(3) Oppose legislation, regulation, and other efforts to deny full reproductive autonomy or interfere with medical decision making and the physician-patient relationship;
(4) Opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions, efforts to enforce criminal and civil penalties or other retaliatory efforts against patients and requirements that physicians function as agents of law enforcement, and attempts by the U.S. Department of Justice to subpoena medical records in cases involving abortion;
(5) Condemn violence directed against abortion clinics and family planning centers as a violation of the right to access health care;
(6) Oppose all restrictions on public funding for reproductive healthcare, including contraception and abortion, both domestically and abroad;
(7) Support global humanitarian assistance for comprehensive reproductive health services, including contraception and abortion;
(8) Support continued funding efforts to address the global HIV epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to the exchange of sex for money or goods; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention.
(9) Support guaranteed coverage of evidence-based abortion services without barriers by all public and private payers, designation of abortion services as an essential health benefit, and collaboration with state medical societies and other interested parties to achieve these goals;
(10) Oppose restrictions on physicians and other health professionals who provide abortion care from participating in or being reimbursed by federal and state funded or subsidized health coverage;
(11) Support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and the FDA's removal of mifepristone's Risk Evaluation and Mitigation Strategy;
(12) Support equitable education on and access to all forms of evidence-based contraception, including emergency contraception and coverage for long-acting reversible contraception device and placement by all public and private payers (including immediate postpartum and post-abortion settings with separate billing from global obstetric fees);
(13) To urge print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices;
(14) Encourage discussion of pain control options, risks, and benefits with patients as part of the shared decision-making process (due to disparities in pain management for gynecological procedures compared to procedures of similarly reported pain) and support research on evidence-based anesthetic and anxiolytic options for long-acting

reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures;
(15) Support that pregnant women with decision-making capacity have the same right to refusal of treatment through advanced directives as non-pregnant women;
(16) Establish a list of Essential Reproductive Health Services, and advocate for requirements for healthcare organizations to clearly publish online and at points of service which Essential Reproductive Health Services are available or restricted at the organization, including referral information for patients regarding other providers that offer these services within the same coverage area;
(17) Advocate that any entity offering crisis pregnancy services (sometimes deceptively known as “pregnancy counseling centers”) fully and publicly disclose all information regarding medical services, contraception, termination of pregnancy or referral for such services, adoption options, or referral for such services that it does or does not provide, as well as any financial, political, or religious associations and their level of compliance with all federal and state laws, including licensing standards and privacy requirements;
(18) Discourage marketing, counseling, or coercion (by physical, emotional, or financial means) by any entity offering crisis pregnancy services that aim to divert or interfere with a patient’s pursuit of medical care;
(19) Oppose all public funds for entities offering crisis pregnancy services that do not provide evidence-based medical information and care to patients.

And furthermore, our AMA-MSS:
(1) supports federal and state efforts to allow appropriately trained and credentialed non-physician clinicians to perform first-trimester medical and aspiration abortions;
(2) supports requirements that all medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including all evidence-based contraception and abortion, emergency care patients (including during and after miscarriages, abortions, and diagnosis of nonviable pregnancy) and fertility services, regardless of the institution’s willingness to perform any of these services, and disclosure of this information to all clinicians employed or seeking employment at the institution;
(3) supports prompt and timely referral of patients to accessible healthcare providers (within the same coverage area) offering reproductive services sought by the patient, when a healthcare provider refuses to provide such care and while avoiding any undue burden to the patients;
(4) opposes all restrictions (including by health facility) that may hinder patients’ timely access to accepted standard of care in both emergent and non-emergent cases of non-viable pregnancy; and
(5) opposes the ability of guardians or petitioners to obtain non-therapeutic sterilizations (eg, not for menstrual problems or pregnancy prevention) for patients with disabilities or other patients placed at a power differential.

RESOLVED, the following MSS Positions:

- 65.046MSS Television Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms
- 75.001MSS Mandatory Parental Notification for Minors Seeking Contraceptives Devices
- 75.005MSS Promotion of Emergency Contraception Pills
- 75.007MSS Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use
- 75.008MSS Opposition to Sole Funding of Abstinence-Only Education
- 75.011MSS Informed Consent with Regards to Advertising and Prescribing Contraceptives
- 170.003MSS Incorporation of Adoption into Public School Health Education Curriculum
- 170.005MSS Teaching Sexual Restraint to Adolescents
- 170.007MSS Teaching Preventive Self Examinations to High School Students
- 170.008MSS Increasing HPV Education
- 170.010MSS Abstinence-Only Education and Federally-Funded Community-Based Initiatives
- 170.011MSS Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula
- 170.015MSS Reducing the Risk of Sexually Transmitted Infections in Patients Age 50 and Older
- 170.016MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula
- 170.019MSS Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula
- 170.020MSS Sex Education Materials for Students with Limited English Proficiency
- 170.021MSS Expansion on Comprehensive Sexual Health Education

be consolidated into the new MSS position:

Comprehensive Sexual Education

The AMA-MSS:

(1) Supports age-appropriate comprehensive sexual education;

(2) Supports the development of programs to teach self-breast examinations and testicular self-examinations to high school students and encourages county medical societies to assist local high schools in implementing such programs;

(3) Opposes requiring parental notification of contraceptive care provided to minors;

(4) Providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media;

Furthermore, our AMA-MSS asked the AMA:

(1) To reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to the LGBTQ+ community;
(2) To actively oppose increasing federal and state funding for abstinence-only education, unless future research shows its superiority over comprehensive sex education in terms of preventing negative health outcomes;
(3) To support the incorporation of information on adoption, sexual violence prevention,dental dams, and other barrier protection methods, and culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils into public school sex education or family planning curricula;
(4) Support efforts in the mass media, schools, and communities to make abstinent sexual behavior more socially acceptable and to help students develop the skills and self-confidence they need to restrict their sexual behavior; and this support will include efforts to increase funding and policies at the local, state and federal levels, though not necessarily at the expense of existing policies and encourage school districts to adopt sex education curricula that have a proven record of reducing teenage sexual activity;
(5) Support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women's groups, health groups, clinics, the public and the media;
(6) To support the development of programs to teach self-breast examinations to female high school students and testicular self-examinations to male high school students and encourage county medical societies to assist local high schools in implementing such programs;
(7) To strongly urge existing school health education programs to emphasize the high incidence of human papillomavirus and to discuss the importance of routine pap smears in the prevention of cervical cancer;
(8) To encourage physicians to educate their patients, particularly those of age 50 and older, on safe-sex practices and on the risk of sexually transmitted infections.

and be it further

RESOLVED, the following MSS Positions:

- 65.055MSS Including Gender Inclusive Language in Menstrual Healthcare
- 75.012MSS Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception
- 75.013MSS Increasing Availability and Coverage for Immediate Postpartum Long-Acting
- Reversible Contraception Placement
- 295.073MSS Inclusion of Lactation Management Education in Medical School Curricula
- 295.077MSS Medical Student Education on Termination of Pregnancy Issues
- 295.129MSS Improving Sexual Education in the Medical School Curriculum

- 295.191MSS Educating Physicians About the Importance of Cervical Cancer Screening for Transgender Men Patients
- 295.206MSS Protecting Medical Student Access to Abortion Education and Training
- 295.234MSS Supporting Minimum Content Standards of LGBTQ+ Health Curriculum in Undergraduate Medical Education
- 310.048MSS Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies

be consolidated into the new MSS position:
Reproductive Care in Medical Education
Our AMA-MSS:
(1) Supports gender-neutral language with regards to reproductive rights including but not limited to menstrual products in medical education, clinical training, and clinical practice;
(2) Supports training for healthcare providers that includes de-gendered language and inclusivity for various period products to better understand the needs of all persons who menstruate;
(3) Encourages medical schools to incorporate lactation management education into the medical school curriculum where appropriate;
(4) Supports education on termination of pregnancy issues be included in the medical school curriculum;
(5) Supports that LCME- and COCA-accredited institutions develop minimum content requirements in LGBTQ+ health curricula, including relevant terminology, health disparities, taking a comprehensive sexual history, developing inclusive clinical environments, gender-affirming care for transgender and nonbinary patients, gender-affirming physical exam skills, sexual health safety and satisfaction, and intersectional experiences of LGBTQ+ people;
(6) supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning, and counseling for unintended pregnancy.

Furthermore, our AMA-MSS asked the AMA to:
(1) Support the training of all primary care providers in the area of preconception counseling;
(2) Encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures;
(3) Encourage all medical schools to train medical students to be able to take a thorough and non-judgmental sexual history in a manner that is sensitive to the personal

attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care;
(4) Issue a public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces the AMA's commitment to helping patients maintain sexual health and well-being;
(5) Support regular cancer and sexually transmitted infection screenings in transgender men when medically indicated;
(6) Support opt-out curriculum on abortion education.

VRC testimony was limited. Your Reference Committee thanks the MSS Governing Council for their efforts on this report and appreciates the division of positions into Abortion and Contraception, Comprehensive Sexual Education, and Reproductive Care in Medical Education. The consolidated positions in each category capture the intent and maintain the spirit of the original positions. Your Reference Committee recommends GC Report D be adopted.

(7) GC REPORT E - MSS EMPLOYMENT & EDUCATIONAL LEAVE POSITIONS REVIEW & CONSOLIDATION

RECOMMENDATION:

GC Report E be <u>adopted</u>.

Thus, your MSS Governing Council recommends that the following recommendations be adopted, the following new consolidated positions be retained as active positions of the AMA-MSS, the original comprising positions be rescinded, and the remainder of this report be filed:

RESOLVED, the following MSS Positions:
- 65.024MSS FMLA-Equivalent for LGBTQ+ Workers
- 270.003MSS Broadening Access to Paid Family Leave to Improve Health Outcomes and Health Disparities
- 270.032MSS Paid Parental Leave
- 270.047MSS Supporting Intimate Partner and Sexual Violence Safe Leave
- 270.048MSS Expanding Employee Leave to Include Miscarriage and Stillbirth
- 295.233MSS Support for Family Planning for Medical Students
- 440.050MSS Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes

be consolidated into the new MSS Position:
Support for Universal, Paid, Family and Medical Leave
The AMA-MSS:

(1) Supports universal paid family and medical leave, especially to a period of 14 weeks or longer, including for at minimum the following conditions:
(a) The conditions outlined by the Family and Medical Leave Act of 1993;
(b) Parental leave policies that equally encourage parents of all genders to take parental leave;
(c) Pregnancy complications, including miscarriage and stillbirth;
(d) Concerns for safety, including but not limited to intimate partner violence, sexual violence or coercion, and stalking;
(e) Provisions to include of any individuals related by blood or affinity whose close association with the employee is the equivalent of a family relationship;

Furthermore, the AMA-MSS asked the AMA to: (1) support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship; (2) recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave and (3) support safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking; (4) support leave policy for miscarriage or stillbirth; (5) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; (6) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation; and (7) advocate for federal and state policies that guarantee employee access to protected paid sick leave.

RESOLVED, the following MSS Positions:
- 270.048MSS Expanding Employee Leave to Include Miscarriage and Stillbirth
- 270.049MSS Amendment to Policy H-405.960, Policies for Parental, Family, and Medical Necessity Leave
- 310.002MSS Parental Leave Benefits for House Staff
- 310.049MSS Equal Paternal and Maternal Leave for Medical Residents
- 295.207MSS Family Planning for Medical Students

be consolidated into the new MSS Position:
Leave During Medical Training
The AMA-MSS supports efforts by medical schools, residency and fellowship programs to develop easily accessible written policies on family and medical leave for medical trainees, including at minimum the following provisions:
(1) The conditions outlined by the Family and Medical Leave Act of 1993;
(2) Leave policy for birth, adoption, and pregnancy complications including stillbirth and miscarriage;
(3) Duration of leave allowed before and after delivery;
(4) Parental leave policies that equally encourage parents of all genders to take parental leave;

(5) Concerns for safety, including but not limited to intimate partner violence, sexual violence or coercion, and stalking;
(6) Extended leave for trainees with extraordinary and long-term personal or family medical tragedies, without loss of status;
(7) Clarification of how time can be made up in order to be eligible for graduation without delay and length of leave that would result in delayed graduation or additional training;
(8) Whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

RESOLVED, the following MSS Positions:
- 305.094MSS Increased Education and Access to Fertility Resources for U.S. Medical Students
- 295.207MSS Family Planning for Medical Students
- 295.239MSS Increased Education and Access to Fertility-Related Resources for U.S. Physicians
- 295.233MSS Support for Family Planning for Medical Students

be consolidated into the new MSS Position:

Increased Education and Access to Fertility Resources for U.S. Trainees
The AMA-MSS:
(1) supports the development of initiatives inclusive of sexual orientation and gender identity by the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, medical schools, residency and fellowship programs, and other appropriate organizations in medical education that promote a culture that is supportive of their medical students and trainees who are parents and to provide openly and easily accessible guidelines and information to prospective and current students regarding family planning including raising awareness about:
(a) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees;
(b) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees;
(c) the high rate of infertility among medical students, trainees, and physicians;
(d) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and work with relevant organizations to increase access to strategies by which medical students and trainees can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage;
(e) breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area;

(2) urges academic and private hospitals and employers to offer counseling for family planning options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians.

RESOLVED, the following MSS Positions be amended to summarize the spirit and convert the request to past tense as applicable:

- 65.051MSS Cultural Leave for American Indian Trainees
- 295.197MSS Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
- 310.058MSS Reporting of Residency Demographic Data

VRC testimony was limited. Your Reference Committee thanks the MSS Governing Council for their efforts on this report and appreciates the division of positions on employment and educational leave. Your Reference Committee agrees that the resolve clauses adequately retain the original spirit of the positions that were consolidated. Your Reference Committee recommends GC Report E be adopted.

(8) GC REPORT F - MSS FIREARM POSITIONS CONSOLIDATION

RECOMMENDATION:

GC Report F be <u>adopted</u>.

Thus, your MSS Governing Council recommends that the following recommendations be adopted and the remainder of this report be filed:

RESOLVED, the following MSS Positions:

- 145.001MSS Handgun Violence
- 145.009MSS Regulation of Handgun Safety and Quality
- 145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks
- 145.013MSS Strengthening our Gun Policies on Background Checks and the Mentally Ill
- 145.015MSS Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers
- 145.016MSS Opposition to Armed Campuses
- 145.017MSS Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21
- 145.018MSS Development and Implementation of guidelines for Responsible Media Coverage of Mass Shootings
- 145.019MSS Increasing Firearm Safety to Prevent Accidental Child Deaths
- 145.020MSS Opposing Unregulated, Non-Commercial Firearm Manufacturing
- 145.021MSS Support for Warning Labels on Firearm Ammunition Packaging

- 145.022MSS AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations
- 145.024MSS Amendment to AMA Policy Firearms and High-Risk Individuals H-145.972 to Include Medical Professionals as a Party Who Can Petition the Court
- 145.025MSS New Policies to Respond to the Gun Violence Public Health Crisis
- 145.026MSS Addressing Default Proceed Sales of Firearms
- 145.027MSS Addressing 'Stand your Ground' Laws
- 145.073MSS Support for Comprehensive Safe Firearm Storage Legislation
- 365.004MSS Hospital Workplace and Patient Safety and Weapons
- 440.119MSS Further Action to Respond to the Gun Violence Public Health Crisis

Be consolidated into the new MSS Position:
Gun Violence Is a Public Health Crisis
Our AMA-MSS recognizes that gun violence is a public health epidemic, and supports evidence-based federal, state, and local approaches to reduce gun violence, including but not limited to the following:
(1) universal background checks and a mandatory minimum 7-day waiting period for people buying guns and/or ammunition through any medium, as well as the prohibition of firearm sales to individuals for whom a background check has not been completed;
(2) strengthening of the National Instant Criminal Background Check System (NICS), including opposing the destruction of any incomplete background checks for firearm sales and advocating 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, via or other means; and average time passed between background check completion and retrieval;
(3) mandated reporting of patients with mental illnesses who pose a risk to themselves or others and procedures by which physicians and other medical professionals, in partnership with appropriate stakeholders, can contribute to the inception and development of petitions to a court for firearm removal when a high or imminent risk of violence is present;
(4) individualized violence risk assessments by mental health professionals , rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks;
(5) expanding prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists;
(6) prohibition of the inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure;
(7) prohibition of "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days;

(8) bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21;
(9) bans on the presence of firearms on school campuses;
(10) federal and state comprehensive safe storage laws and child access prevention laws;
(11) evidence-based community firearm violence interruption programs and hospital-based violence interruption programs;
(12) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of firearms and their component parts;
(13) bans on: a) the unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; and b) the production and distribution of 3-D firearm blueprints;
(14) application of the same quality and safety standards to both domestically manufactured and imported firearms;
(15) smart gun technology on all firearms that only allows the lawful owner to use the weapon;
(16) use of taxes on firearm and ammunition sales to cover medical bills for victims of handgun violence and to fund public education on violence prevention;
(17) requirements that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum (a) text-based statistics and/or graphic picture- based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms;
(18) restrictions on the use of deadly force by firearm under "Stand Your Ground" laws when it can be reasonably avoided;
(19) development of guidelines by the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations for media coverage of mass shootings in a manner unlikely to provoke additional incidents;
(20) restrictions on guns and tasers in civilian healthcare delivery settings and comprehensive training of security personnel focusing on patient safety and empathy; and
(21) refusal by all candidates for public office of contributions from any organization that opposes public health measures to reduce firearm violence.

Our AMA-MSS asked the AMA to support many of these approaches as well and furthermore asked the AMA to convene a task force for the purposes of working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun

violence; and reporting annually to the House of Delegates on the AMA's efforts to reduce gun violence.
and be it further

RESOLVED, the following MSS Positions:
- 145.004MSS Prevention of Unintentional Firearm Accidents in Children
- 145.011MSS Gun Safety Counseling in Undergraduate Medical Education
- 145.014MSS Preventing Fire-Arm Related Injury and Morbidity in Youth
- 145.023MSS Amend H-145.976, to Reimburse Physicians for Firearm Counseling
- 295.209MSS Addressing the Need for Firearm Safety in Medical School Curricula

Be consolidated into new MSS Position:
Firearm Safety Education and Counseling
Our AMA-MSS asked the AMA to support evidence-based efforts to increase education and patient counseling to reduce gun violence, including but not limited to the following:
(1) collaboration with relevant parties to increase firearm safety education, including with firearm owners and training organizations to develop and distribute materials appropriate for the clinical setting;
(2) the inclusion of gun violence epidemiology, firearm safety education, and patient counseling strategies in undergraduate medical education and the development of modules by the Association of American Medical Colleges, Agency for Healthcare Research and Quality, and other relevant organizations, on topics including but not limited to:
(a) inquiring as to the presence of household firearms as a part of childproofing the home;
(b) educating patients to the dangers of firearms to children;
(c) encouraging patients to educate their children and neighbors as to the dangers of firearms;
(d) routinely reminding patients to obtain firearm safety locks and store firearms under lock and key;
(3) reimbursement structures that incentivize physicians to counsel patients on firearm safety; and
(4) laws against the restriction of evidence-based firearm safety counseling by physicians, other health professionals, and medical students.

VRC testimony was limited. Your Reference Committee thanks the Governing Council for their efforts on this report and appreciates the division of positions on firearms. Your Reference Committee agrees that the consolidations are thorough and preserve the original asks of all positions consolidated. Your Reference Committee recommends GC Report F be adopted.

(9) GC REPORT G - REVIEW & CONSOLIDATION OF POSITIONS RELATING TO MSS GOVERNANCE

RECOMMENDATION:

GC Report G be adopted.

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be filed:

RESOLVED, MSS Position 665.014MSS Region Restructure Assessment During IOP Revision Process be amended by addition and deletion as follows:

~~(1) The existing AMA-MSS Region structure will remain unchanged and~~

~~(2) the~~ (1) AMA-MSS will annually assess and report to the MSS Assembly each Region's membership numbers and degree of engagement with the AMA-MSS, including effects on Assembly attendance and quorum and Regional Delegate and Regional Alternate Delegate apportionment,

(2) in preparation for or at the time of review for possible revisions of the MSS IOPs a comprehensive report will be prepared for the MSS Assembly, ~~least every 5 years~~ to explore current barriers to medical student participation in the AMA including but not limited to cost and value of membership and conference attendance and consider potential changes to the Region structure and function (i.e. state and school delegate allocation allocated in each Region) to be included in those revisions; and be it further;

(3) Region bylaws will be reviewed and assessed by each Region annually during the leadership transitions and strategic planning process;

RESOLVED, that the recommendations for consolidation actions specified in Appendix A - F of this report be retained as official, active positions of the AMA-MSS;

RESOLVED, the following MSS Positions:

1. 630.011MSS Improved Access and Programming of Non-Scientific Issues in Medicine
2. 630.019MSS MSS Master List of Dates
3. 630.042MSS Improving AMA-MSS Communication
4. 640.003MSS States Regional Chairs
5. 645.013MSS Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD
6. 650.002MSS Improved Communications Between MSS and RFS and Between RFS and YPS

be consolidated into the new MSS Position:

Optimizing MSS Communications
AMA-MSS will continue to support and explore strategies to optimize communications with general members, including at minimum:

(1) Production of an electronic newsletter;
(2) Maintenance of virtual platforms for direct communication with members (i.e. GroupMe) at the national and regional levels;
(3) Maintenance of an easily accessible and regularly updated list of important events and deadlines for MSS and AMA activities;

(4) Maintenance of an easily accessible list of items important to the MSS that will be coming before the AMA House of Delegates, updated before each HOD meeting;
(5) Maintenance of an easily accessible list of outcomes of items important to the MSS considered at the AMA House of Delegates updated after each House of Delegates meeting;
(6) Maintenance of an easily accessible list of implementation outcomes of items important to the MSS considered at the AMA House of Delegates upon publication of the annual House of Delegates Follow Up Implementation Report;
(7) Regular dissemination of information about shared initiatives with other AMA entities;
(8) Ensure MSS Regions maintain active and timely communication with MSS delegates and other general Region members regarding responsibilities and opportunities; and
(9) Developing and maintaining a series of free online materials providing detailed information on MSS functions and engagement opportunities;

and be it further

RESOLVED, the following MSS Positions:

7. 630.050MSS Creating a Community Service Project
8. 645.015MSS Non-Voter Participation During the Assembly Portion of the AMA-MSS Annual and Interim Meetings
9. 645.012MSS Health Policy Programming

be consolidated into the new MSS Position:

<u>Expanding Programming at MSS Meetings</u>
The MSS Governing Council will continue to explore and implement additional programming for attendees of the MSS Annual and Interim Meetings, including but not limited to health policy educational opportunities, residency fairs, workshops, lectures, community service projects, and networking and social opportunities.

and be it further

RESOLVED, the following MSS Positions:

- 530.023MSS Equal Opportunity in Professional Affiliations for Physicians
- 530.024MSS Medical Student Participation in Professional Organizations
- 655.001MSS Student Membership in State Medical Societies
- 655.003MSS Dual State Society Membership for Medical Students
- 655.002MSS Membership Recruitment Methods

be consolidated into the new MSS Position:

<u>MSS Positions Consolidated by New Position: Medical Student Participation in State and Local Professional Organizations</u>
AMA-MSS asked the AMA to support and encourage student membership and participation in state and local medical societies by:
(1) urging its state medical associations and constituent societies to:
(1) review and study membership provisions of their bylaws to maintain fair membership standards for equal access for all physicians and medical students
(2) seek the removal of any impediments to student membership;

(3) encourage societies to establish student dues that do not exceed 50 percent of the national student dues;
(4) offer membership options for students who are enrolled in medical school for longer than four years;
(5) oppose policy that directly or indirectly restricts or restrains any individual member's freedom of choice with respect to professional societies for which they are eligible;
(6) provide all medical students equal access to funding and opportunity within the realm of their society.
(7) allow medical students to hold membership in the state society in which they attend medical school and also an associates membership in their state of permanent residence not be counted in determining the number of AMA delegates representing a state.
(8) support medical student representation in state delegations to the AMA House of Delegates, with the goal of having a proportional number of delegate seats based on student membership.

(2) working with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.

and be it further

RESOLVED, the following MSS Positions:

- 530.016MSS Creation of Additional Dues Structure for Resident & Fellow Section
- 655.022MSS MD/PhD AMA Membership
- 655.017MSS Multi-Year Membership Benefit
- 655.004MSS Medical Student Membership Benefits
- 655.025MSS Increasing the Efficiency of Student Membership Application Processing

be consolidated into the new MSS Position:

<u>Medical Student Dues, Incentives, and Funding</u>

Our AMA-MSS asked the AMA to:

(1) create discounted multi-year dues options for medical students and residents for all program lengths including students and residents who take extra years for additional degrees, research, and other leaves of absence while ensuring that recruitment rebates apply to these options;
(2) support medical student recruitment efforts by providing a tangible membership benefit linked to the multi-year membership option on a continual annual basis.
(3) provide benefits, free of charge, to new members processed before January until official membership begins in January according to the AMA calendar.
(4) provide contact information for AMA staff member responsible for benefit inquiries and grievances;
(5) continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members.
(6) explore mechanisms to mitigate costs associated with medical student participation at national, in-person AMA conferences.

and be it further

RESOLVED, the following MSS Positions:

- 655.002MSS Membership Recruitment Methods
- 655.005MSS Recruitment Information in AMA and MSS Pamphlets
- 640.003MSS States Regional Chairs
- 655.034MSS Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA
- 655.028MSS The Designation of Permanent Membership Positions Within Local AMA-MSS Chapters
- 350.019MSS Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level
- 655.015MSS Eligibility of Medical Students to Join the AMA while Enrolled in a JointDegree Program
- 630.011MSS Improved Access and Programming of Non-Scientific Issues in Medicine
- 655.018MSS Membership Retention into Residency
- 655.033MSS Establishing a Joint MSS and RFS Approach for Recruitment Initiatives for Incoming MSS Members to the RFS
- 655.024MSS Improving Federated Membership Recruitment and Portability

be consolidated into the new MSS Position:

Supporting MSS Membership Recruitment and Retention

Our AMA-MSS Governing Council will support and encourage AMA membership through exploring a variety of recruitment and retention methods and implementing, at minimum, the following strategies:

(1) supporting offering medical students free membership in the AMA and/or constituent societies;
(2) stressing and distinguishing the benefits of membership on the national, state, and county/local levels in recruitment materials;
(3) Collaborating with Region Leadership, Medical Student Outreach Program, Marketing and Membership Experience staff and other appropriate AMA staff to:
    (a) encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist;
    (b) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections;
    (c) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and
    (d) ensure every medical school designates a permanent position within their local campus section to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the local campus section provides the individual's name and contact information to the MSS Governing Council, pertinent Region Leaders, and AMA Medical Student Section Outreach Program when local campus section leadership transitions, or at least annually.
    (e) support the collaboration between local chapters and allied medical student organizations to increase underrepresented minority medical student participation in the AMA-MSS including the creation of a local DEI Chair and/or liaisons to national medical student organization chapters at their local institution;
    (f) use peer-to-peer recruitment to identify and recruit students on an individual basis that are enrolled in joint degree programs and who begin their education in disciplines other than medicine.
    (g) explore methods of disseminating information from the AMA-MSS to local chapters with the goals of increased access, and program development;
    (h) develop and promote a series of free online modules and presentation

templates on a variety of topics which can be used by general members and local campus section leadership to learn about the MSS and other topics of importance to future physicians;

(4) explore ways to increase awareness of the Medical Student and Resident & Fellow Sections in order to increase membership retention during the transition to residency through strategic collaboration with (a) the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (b) medical school deans to find better means to increase awareness such as targeted informational sessions and increased presence at match day and graduation events.

(5) supporting the development of a system whereby medical student, resident/fellow, and young physician members of the AMA, state, and county medical societies may rapidly transfer their new or existing memberships to the appropriate state and county medical societies of their new program or practice;

and be it further

RESOLVED, the following MSS Positions be rescinded:

1. 630.049MSS AMA Medical Student Section Vision Statement
2. 630.069MSS Developing our Regions
3. 630.073MSS Voting Rights of MSS Speaker and Vice Speaker
4. 630.076MSS Sunset Report Update
5. 640.011MSS Region Chair Elections
6. 660.001MSS Questions of Parliamentary Procedures
7. 660.017MSS Campaign Reform
8. 660.026MSS AMA-MSS: Officers – Nomination, Election, and Tenure
9. 660.036MSS Creating an AMA-MSS Election Task Force
10. 660.037MSS Expanding the AMA-MSS Governing Council to Include a Diversity, Equity, & Inclusion Officer
11. 665.001MSS Strengthening of Regional Internal Operating Procedures (IOPs), Creation of Regional Coordinating Committees, and Creation of Membership/ Recruitment Chair for Each Region
12. 665.012MSS Evaluation of AMA-MSS Region Bylaws
13. 665.015MSS Reevaluation of AMA-MSS Region Bylaws
14. 665.017MSS Re-evaluation of AMA-MSS Region Bylaws

and be it further

RESOLVED that the following MSS Positions be retained as official, active positions of the AMA-MSS:

1. 530.003MSS JAMA's Editorial Freedom
2. 530.004MSS Conference Registration Fees
3. 530.006MSS Donation of Medical Journals
4. 530.012MSS Product Endorsements
5. 530.017MSS Creation of a National Labor Organization for Physicians
6. 530.020MSS Establishing an AMA International Health Consortium
7. 530.025MSS Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations
8. 530.026MSS Anti-Harassment Training
9. 530.027MSS Environmental Sustainability of AMA National Meetings
10. 535.001MSS Commendation to the AMA Board of Trustees
11. 535.003MSS Disclosure of Funding Sources and Industry Ties of Professional Medical

		Associations and Patient Advocacy Organizations
12.	540.002MSS	Council Elections and Visibility
13.	550.008MSS	Medical Student Regional Delegate Apportionment
14.	630.007MSS	MSS Resolutions
15.	630.022MSS	Recycling at AMA-MSS Meetings
16.	630.025MSS	Changes in MSS Resolutions Forwarded to the AMA House of Delegates
17.	630.041MSS	Inclusion of AOA-Accredited Schools in Policy Language:
18.	565.001MSS	MSS Political Action
19.	565.002MSS	Preserving the AMA's Grassroots Legislative and Political Mission
20.	565.003MSS	Building AMA-MSS Membership through Promotion of AMPAC and State Medical
		PACs
21.	645.001MSS	Use of the Term "Assembly"
22.	645.016MSS	Student Academy of the American Academy of Physician Assistants Official
		Observer
23.	645.019MSS	European Medical Student Association (EMSA) – Official Observer
24.	645.026MSS	Advocating for the Continuation of a Fall Meeting of the Medical Student Section
25.	645.031MSS	MSS Action Items

VRC testimony was limited. Your Reference Committee thanks the MSS Governing Council for their work on this report and agrees that the consolidations appropriately encompass the original positions. Your Reference Committee recommends GC Report G be adopted.

(10) GC REPORT H - MSS ALCOHOL-RELATED POSITIONS CONSOLIDATION

RECOMMENDATION:

GC Report H be <u>adopted</u>.

Thus, your MSS Governing Council recommends that the following recommendations be adopted and the remainder of this report be filed:

RESOLVED, the following MSS Positions:

- 30.011MSS Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements
- 370.019MSS Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease

be consolidated into the new MSS Position:
Supporting the Use of Evidence-Based Guidelines in Transplant Evaluation
AMA-MSS supports:
(1) Encouraging transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis;

(2) The use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease; and be it further

RESOLVED, the following MSS Positions:

- 30.003MSS Age Requirement for Purchase of Non-Alcoholic Beer
- 30.005MSS Boating Under the Influence
- 30.006MSS Support of Programs that Discourage Adolescent Alcohol Consumption
- 420.002MSS Substance Abuse During Pregnancy

be consolidated into the new MSS Position:
Supporting Education on the Health Risks of Alcohol
The AMA-MSS supports education on the health effects of alcohol, including but not limited to:
(1) education on the dangers of alcohol and drug consumption for the safe operation of recreational watercraft;
(2) working with adolescents to both raise awareness of the dangers of alcohol consumption by minors as well as to curtail underage drinking in their local populations;
(3) efforts to educate the general public, especially adolescents, about the effects of alcohol use disorder and substance use disorder on prenatal and postnatal development;
(4) efforts to educate the public and consumers relating to the alcohol content of so-called "non- alcoholic" beverages and other substances, including medications, especially as related to consumption by minors; and be it further

RESOLVED, the following MSS Positions:

- 30.003MSS Age Requirement for Purchase of Non-Alcoholic Beer
- 30.005MSS Boating Under the Influence
- 30.007MSS Drunk Driving Prevention through Designated Driver Use Promotion
- 30.008MSS Support for Medical Amnesty Policies for Underage Alcohol Intoxication
- 30.009MSS Sobriety Checkpoints
- 30.010MSS Opposition to Alcoholic Industry Marketing Self-Regulation

be consolidated into the new MSS Position:
Supporting a Harm Reduction Approach to Alcohol Use
The AMA-MSS supports a harm reduction approach in policies related to alcohol consumption, including but not limited to:
(1) urging businesses that serve alcohol to offer incentives such as free admission, reduced food prices, and free non-alcoholic beverages to patrons who elect to be designated drivers
(2) efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking

emergency medical attention for themselves or others, while discouraging underage use of alcohol.
(3) accurate and appropriate labeling disclosing the alcohol content of all beverages including so-called "non-alcoholic" beer and of other substances as well, including over-the-counter and prescription medications with removal of "non- alcoholic" from the label of any substance containing any alcohol
(4) enforcement of regulations regarding boating under the influence of alcohol and other drugs;
(5) the use of sobriety checkpoints to deter driving following alcohol consumption;
(6) working with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints;
(7) federal and/or state oversight for all forms of alcohol advertising

VRC testimony was limited. Your Reference Committee thanks the MSS Governing Council for their efforts on this report and agrees the three consolidated positions encompass the original positions. Your Reference Committee recommends GC Report H be adopted.

(11) GC REPORT I - GUIDELINES FOR OFFICIAL OBSERVERS IN THE AMA-MSS ASSEMBLY

RECOMMENDATION:

GC Report I be <u>adopted</u>.

RESOLVED, that our AMA-MSS will:

a) invite and consider observer applications from national student organizations that have a vested interest in addressing issues in healthcare and public health, have a majority student membership, and are expected to add a unique perspective or bring expertise to MSS Assembly;

b) require applications to include the organization’s rationale for observer status in the MSS, any governing documents (or if unavailable, a description of the organization’s history, structure, operations, and activities), a list of all of the organization’s sources of financial support, and a list of all of the organization’s affiliations with other entities;

c) require representatives of observer organizations to be students chosen in a fair and equitable manner by their organization’s leadership or membership and certified by their organization’s leadership;

d) allow observer representatives to present their organization's policies, opinions, and interests at appropriate times in the MSS policy process and in the MSS Assembly and report on MSS actions to their organization's leadership and membership; and

e) use a biennial review process to renew or terminate an organization's observer status analogous to that used for national medical student organizations, with the Governing Council making a recommendation to the MSS Assembly, who will vote to make the final determination.

VRC testimony was limited. Your Reference Committee thanks the Governing Council for their extensive efforts in this report and agrees that the recommendations of this report fill a gap in current MSS positions due to the absence of guidelines as referenced in MSS IOP 10.3.5.1. Your Reference Committee recommends GC Report I be adopted.

(12) CEQM COLA REPORT A – OPPOSING PRIVATE EQUITY ACQUISITIONS OF HEALTHCARE PRACTICES

RECOMMENDATION:

CEQM COLA Report A be <u>adopted</u>.

Your Committee on Economics & Quality in Medicine and Committee on Legislation & Advocacy (COLA) recommend that the following recommendations are adopted in lieu of Resolution 015 and the remainder of this report be filed:

RESOLVED, that our AMA-MSS oppose the acquisition of healthcare practices by private equity (PE) firms, especially when such acquisitions are not immediately necessary for the continued operations of such practices; and be it further

RESOLVED, that our AMA-MSS support increased regulation of PE acquisitions in order to better align with the goals of healthcare.

VRC testimony was supportive of the report. Your Reference Committee agrees with testimony that the report is well-researched and comprehensive. We believe this report establishes an important internal position that can be utilized through various potential efforts. Your Reference Committee recommends CEQM COLA Report A be adopted.

(13) SD REPORT A – MSS POLICY PROCESS AND HOD RESOLUTION QUEUE

RECOMMENDATION:

SD Report A be <u>adopted</u>.

1) That our AMA-MSS
   a) amend MSS Position 165.020MSS, "Single Payer Solution," as follows to incorporate the content of 165.022MSS, "Expanding AMA's Position on Healthcare Reform Options" and 165.030MSS, also identically titled "Expanding AMA's Position on Healthcare Reform Options," to create a unified consolidated position,
   b) accordingly rescind 165.022MSS and 165.030MSS, and
   c) with the concurrence of a vote by acclamation from your MSS Caucus, withdraw the resolution related to 165.030MSS from our HOD queue:
      i) Note: 165.030MSS was adopted at MSS A-23 and was in our queue to be submitted to a future HOD meeting. A similar resolution sponsored by the New England Delegation was submitted to and debated at HOD I-23. Ultimately, the resolution was partially referred, with expected report back at HOD I-24. Submission of an MSS resolution is no longer necessary at this time, as we will use our existing internal MSS positions to advocate on the resultant HOD I-24 report. These changes also reflect protocols used by the MSS Governing Council and Standing Committees for the MSS A-24 Sunset Review Process to clarify when the MSS asked for an external action at HOD. The combined policy timeline is provided for context. The word "national" is added to the title differentiate this position from 165.017MSS, "MSS Support for State-by-State Universal Health Care," but is intentionally left out of the underlined addition, as our external actions in HOD are specifically about "single payer" and do not differentiate between national or state, though of course "national" would be the common interpretation.

165.020MSS <u>National</u> Single Payer <u>Healthcare</u> ~~Solution~~

AMA-MSS supports the implementation of a national single payer system<u>.</u> ~~; and (2) w~~<u>W</u>hile our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS and 165.024MSS.

<u>Our AMA-MSS asked the AMA to remove opposition to single payer from AMA policy, adopt a neutral stance on single payer healthcare reform, and instead evaluate single payer proposals by the extent to which they align with the AMA's policy on healthcare reform.</u>

(MSS Res 12, A-17) (MSS Res 40, I-17) (AMA Res 108, A-18, Referred) (CMS Report 2, A-19, Not Adopt) (Amended: MSS GC Report A, A-23) (MSS Res. 048, A-23) (AMA Res 818 from New England Delegation, I-23, Referred)

2) That our AMA-MSS amend MSS Position 665.016MSS, "Amending G-630.140 Lodging, Meeting Venues and Social Functions," as follows and with the concurrence of a vote by acclamation from your MSS Caucus, accordingly withdraw this resolution from our HOD queue:
    a) *Note: This resolution was originally passed at MSS A-19, prior to COVID, when the MSS Physicians of the Future Summit (POTFS) regional meetings were still held in-person. Since COVID, POTFS has moved entirely virtual, and region leadership has repeatedly indicated no interest in moving back to an in-person format due to logistical difficulties and inequities in access to travel, lodging, etc for yet another MSS-related meeting. However, your MSS Governing Council recognizes that the opinions of our MSS membership and region leadership may change in the future and keeping options available long-term for upcoming generations of MSS members is important. For example, after the most recent POTFS in January 2024, interest was again renewed in possibly hosting MSS regional meetings in-person. At HOD I-22, Resolution 602 introduced by the Southeastern Delegation (16 states, DC, and PR), TX, and the American College of Radiology sought to amend G-630.140 to remove the restrictions on AMA meeting venues altogether. Due to the increasing criminalization of abortion, gender-affirming care, and other types of care, as well as increased risk of violence and discrimination toward individuals from minoritized communities, the removal of restrictions altogether would force AMA members to risk their safety to attend and participate in AMA meetings. Our MSS Caucus did not support the resolution, but did support the one-word amendment to G-630.140 in line with 665.016MSS to exempt MSS regional meetings from those restrictions, due to the far more limited number of options (or sometimes, no options) in a region as opposed to the entire nation. Students who are already in states that would be restricted should have the future opportunity to propose hosting MSS meetings near them, especially in regions where many or all states have prohibitive laws. MSS regions' members should have autonomy over deciding collectively where to hold their meetings. These considerations do not apply to AMA national meetings. Our MSS Chair Natasha Topolski (then Chair-Elect) testified to this effect on behalf of our MSS Caucus in the Reference Committee F hearing. The resolution was referred to the AMA Board of Trustees. They released their report at HOD I-23, which recommended removing the restriction altogether in line with Resolution 602. However, the report was referred back, with the next iteration expected at HOD A-24. Your Chair has communicated extensively and repeatedly with multiple Trustees regarding the MSS' view that restrictions*

should remain in light of increasing concerns, but that exceptions should be made for MSS meetings that are not national. Trustees have confirmed that these points have been discussed at length by the Board. While the Board's A-24 iteration of the report has not yet been released, Trustees have confirmed that even if HOD votes to keep the broad restrictions in place, MSS national leadership can request exceptions as needed to be approved by the Board on a case-by-case basis. Given the long history and many conversations on this topic and due to the sensitivity over opening this AMA policy to amendments and our MSS Caucus' previous desire to retain restrictions for national meetings, your MSS Governing Council believes that this is a reasonable and appropriate compromise. Because our Chair has directly and repeatedly made this request to the Board and received a response that adequately addresses the initial goal of the resolution, your Section Delegates believe that this equates to "asking the AMA" (functionally the same as submitting the resolution) and has fulfilled the goal of this MSS Position's original language. We offer appropriate amendments to reflect both the previous requests and the plan for requesting exceptions moving forward.

665.016MSS Amending G-630.140 Lodging, Meeting Venues and Social Functions

Our AMA-MSS asked the AMA to support exemptions to our AMA policy on locations of meetings organized or primarily sponsored by the AMA, in order to allow the MSS to hold regional, state, or local meetings for MSS members in areas that would otherwise be restricted under AMA policy. Our AMA-MSS, via the MSS Governing Council and Medical Student Trustee, will request that the AMA make such exceptions as needed.

~~AMA- MSS will ask our AMA to amend policy G-630.140 Lodging, Meeting Venues, and Social Functions to read as follows:~~
~~Lodging, Meeting Venues, and Social Functions G-630.140~~
~~(1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost and similar factors. (2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel, or in a hotel close in proximity. (3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances to justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to~~

~~hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including but not limited to, policies based on race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.~~

3) That our AMA-MSS:
    a) amend 645.032MSS, "Resolution Task Force Update 2022" and divide it into two policies as follows; and
    b) accordingly rescind 630.007MSS and 630.025MSS, as their content has been incorporated into the proposed amendments to 645.032MSS and clarified to reflect longstanding routine MSS practice.

Note: Most of the below changes make editorial corrections to the formatting of the MSS A-23 Resolution Task Force report recommendations in our Digest to better reflect the Task Force's intent of two positions with their corresponding titles, instead of the structure of the recommendations also being copied over ("adopt the following," "and be it further"). Additionally, "2022" is an error. The last paragraph is struck because (a)'s ask for rescission of policies is simply an administrative directive and does not need to be retained in the Digest after its completion, and the outdated and confusing "Statements of Support" section has been removed; (b) was added to support the creation of our MSS Archives Task Force to study strategies for institutional memory, and since the findings of their study are now available via their report, the "investigation" is complete and this language is no longer needed here in this position, as any further actions on this front should be appropriately included as recommendations of that report; and (c) has been incorporated as the 8th point of 645.032MSS with a clarification of the scope of the re-evaluation and a definitive timeline.

One substantive change is included, to delete the explicit use of reaffirmation as a standard type of recommendation on MSS resolutions moving forward. To be very clear, this does NOT propose removing reaffirmation as part of the sunset process, as that would still remain and is clearly outlined in 630.044MSS. This only refers to the use of reaffirmation on a given new MSS resolution introduced for debate by the Assembly.Since the MSS A-23 Resolution Task Force report, reaffirmation in the MSS has no

relationship to resolutions requesting external action in HOD whatsoever. Any external MSS resolutions found to be redundant with AMA policies are simply recommended to be "not adopted" by the Reference Committee with an explanation of the relevant policies. Despite a few concerns that this might increase the likelihood of resolution adoption due to the negativity associated with "not adopt," the MSS has fortunately seen no deficits from the removal of reaffirmation as an option for external resolutions. This is likely due to a combination of extensive education on the purpose and impact of quality resolutions across the MSS, redirection of resolutions into alternative advocacy pathways, and an atmosphere that does not frame defeat of a resolution as a negative prospect but simply an outcome of a robust and thoughtful democratic process and a common experience for many experienced members that should be destigmatized, as many authors go on to pass resolutions in the future.

Aside from the sunset process, which is clearly defined in 630.044MSS, reaffirmation in the MSS is now only used for resolutions requesting an MSS internal stance and can only be used to reaffirm existing MSS positions. Given the very few internal MSS resolutions, the range of items for which reaffirmation can even be considered is quite narrow. Additionally, external resolutions are generally of higher import and priority to the MSS; if we are able to successfully regulate the passage of external resolutions via "not adopt" alone, we have no good reason to specifically keep a special mechanism of reaffirmation for internal resolutions when we could similarly simply "not adopt" those resolutions if needed. We also believe that the continued removal of reaffirmation has the potential to greatly reduce possible confusion over the complexities of parliamentary procedure in the MSS Assembly. Currently, all our parliamentary procedure resources must include reaffirmation, despite its extremely limited potential for use. Students already regularly report difficulty learning parliamentary procedure (including on feedback surveys), especially in the compressed timeframe of the Assembly, so attempts to further streamline our processes to remove unnecessary and unused components is likely to have benefit with no deficit.

Furthermore, your Section Delegates considered whether removing internal reaffirmation in the MSS Assembly would potentially have any downstream effects on MSS members who eventually attend HOD without knowledge of the function of reaffirmation. However, even on that point, your Section Delegates believe this is unlikely to

have any effect. Aside from the HOD sunset process (which is similar to the MSS process), reaffirmation not only plays a relatively limited role in HOD, but is also a unique and distinct process itself that functions very differently from MSS, with no significant relationship to our use in the Assembly (eg, initial recommendations are made by Council staffs, determinations by a Rules Committee, extractions via a separate process prior to Reference Committee hearings, etc). Each cohort of MSS Caucus members has to be yearly taught anew how HOD reaffirmation works anyway because it is so different from the MSS Assembly's historical use, with explicit clarifications that the HOD process is separate and has its own dynamics to consider that cannot depend on an understanding of MSS Assembly reaffirmation. The use of reaffirmation in the HOD is also far more aggressive than its typical use in the MSS, as it is commonly applied to many resolutions that the MSS believes would be very impactful and high-quality, as well as similar resolutions from other delegations. In fact, at HOD I-23, every single resolution was removed from the Reaffirmation Consent Calendar. At the 2023-2024 HOD Resolution Modernization Task Force's Open Forum at HOD I-23, discussions also occurred on whether the Reaffirmation Consent Calendar should no longer be used in the future. We are likely to see recommendations regarding this issue from the Task Force's final report at HOD A-24.

The removal of reaffirmation from the MSS Assembly would actually probably only improve learning, since confusion would be reduced over Caucus members' previous knowledge of MSS reaffirmation and trying to differentiate between them; they would only have to primarily focus on learning the HOD reaffirmation process. Furthermore, reaffirmation in HOD is a fairly brief stage and is almost entirely managed by our Section Delegates anyway, so its wide relevance to other members beyond them is limited. Additionally, since the MSS would still retain reaffirmation via our sunset process, students still have the opportunity to learn about its meaning from those annual reports and the annual sunset review process conducted by our standing committees and their hundreds of members, so additional protections to ensure that members are aware of its importance are already in place. This would also provide the necessary education to understand how reaffirmation is used in the HOD sunset process. For the likely myriad and multifaceted benefits of simplification without any evidence to expect negative effects, we propose removing reaffirmation as a standard action on MSS resolutions.

We propose incorporating the content of 630.007MSS and 630.025MSS into 645.032MSS, in order to keep all of our MSS positions relating to the policy process in one unified place for clarity and ease. These two positions were the only ones reaffirmed by the MSS A-23 Resolution Task Force, but were not incorporated into the main policy. We believe these positions, regarding the inappropriate editing of MSS resolutions, are highly important and want to make sure they are easily seen whenever any member references 645.032MSS.

The content of 630.007MSS is incorporated into the newly added clause 9 of 645.032MSS almost verbatim, with some restructuring of the sentence for syntactical purposes, the removal of the word "councils" as our MSS does not have any councils besides the Governing Council, and a clarification and expansion of the types of entities who cannot edit resolutions (including the Governing Council). We also add "reformatting," as this is currently longstanding practice for many years in the MSS that staff will reformat resolutions to fit the resolution template accordingly.

The content of 630.025MSS is incorporated into the newly added clause 10 of 645.032MSS. To reflect current longstanding practice for many years in the MSS, we clarify that this position is solely intended to apply to the resolve clauses of MSS-adopted resolutions, for which this serves as an important protection to preserve and respect the democratic voice of the MSS Assembly. However, for many years, Section Delegates have revised the titles and whereas clauses of resolutions after their adoption by the MSS and prior to their submission to HOD, while still retaining and respecting the spirit of the authors' arguments. (This is also common practice for the Resident & Fellow Section.) The reasons for this are myriad and have significant implications for the success of resolutions in HOD:

- *whereas clauses can be updated with new information or additional references to strengthen an argument (this was especially important due to the backlog, as years could pass before HOD submission.*
- *whereas clauses and titles can be significantly condensed and shortened to be easier to read for HOD delegations (a very common complaint),*
- *whereas clauses can be revised for clarity or corrections in arguments that may have inadvertently been misrepresented during the drafting process, whereas clauses referring to MSS-specific arguments (such as existing MSS positions)*

that may be helpful to support the resolution's passage in the Assembly can be removed prior to HOD, where they would no longer be relevant,

- *whereas clauses that refer to specific specialties or medical societies can be revised or removed to avoid potentially offending another delegation or misrepresenting their position (another common complaint),*
- *whereas clauses and titles can be adjusted to better reflect the content of the final resolves adopted by the MSS Assembly,*
- *whereas clauses can be revised for general improvement on a longer, more relaxed timeframe before HOD, rather than being beholden to authors who may often have limited bandwidth to put full effort into writing whereas clauses during the drafting stage in MSS, and*
- *titles can be adjusted to be more attractive or less provocative and possibly offensive for other HOD delegations or to increase timeliness, to encourage reading the full resolution and resolves before jumping to conclusions.*

While your Section Delegates agree that resolve clauses should be highly protected, the ability to respectfully revise whereas clauses and titles is an important one, similar to all the other actions taken by our MSS Caucus to testify on resolutions, make arguments, and vote on possible amendments and compromises to advocates to give our resolutions the best possible chance of changing AMA policy. Therefore, we ask to clarify that the content of 630.025MSS refers to protecting the resolve clauses of MSS-adopted resolutions from inappropriate edits, and does not apply to other components of the resolution (whereas clauses, titles, references, and existing policy).

645.032 <u>MSS Policy Process</u> ~~**RESOLUTION TASK FORCE UPDATE 2022**~~

~~AMA-MSS adopt the following as our MSS Policy Process:~~

1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis.
2. The draft resolution review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS standing committees; MSS members with significant HOD experience; and MSS members who liaise

with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies.

3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business.

4. Resolutions submitted by the correct deadline in the correct format as determined by the MSS Section Delegates prior to start of the policy cycle may not be rejected for submission for consideration by the MSS Assembly based on their content after organizational review for legal issues.

5 . Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “not adoption,” ~~“reaffirmation in lieu of,”~~ etc. The order of items in each category will be randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. Any MSS member may extract any item from the Reference Committee Report for debate at the MSS Assembly. No other requirements, such as testimony or votes, are necessary for an item to be extracted. The Section Delegates shall provide opportunities for extraction both in advance of the MSS Assembly remotely and at the beginning of the Assembly. Extractions made in advance of the MSS Assembly should be published in real-time as they are submitted.

6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be made available on the AMA-MSS Web site, with updates made prior to the beginning of the Policy Cycle for each Annual and Interim Meeting of the Assembly.

7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions.~~; and be it further~~

8. Upon final submission to the MSS for consideration by the Assembly, MSS resolutions, including the “whereas” and “resolve” clauses and footnotes, may not be altered by staff or any MSS leader, member, committee, or other entity prior to the MSS Assembly Meeting without the consent of the author, with the exception of retyping and reformatting.

9. The MSS Section Delegates (when they agree) may make grammatical or syntax changes to the resolve clauses of MSS resolutions after they are adopted by the Assembly and before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the resolve clauses be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to resolve clauses before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolve clauses. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution.
10. Our AMA-MSS will reevaluate 645.032MSS, 645.033MSS, and the MSS Policy Process in general in a Governing Council report to be presented to the MSS A-26 Assembly.

645.033MSS Additional MSS Caucus Operations

~~AMA-MSS adopt the following as Additional MSS Caucus Operations:~~

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.
2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation.
    a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus.
    b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.

~~AMA-MSS (1) rescind all statements of formal support for AMA policies listed in the section "AMA-MSS Statements of Support for HOD Policies" of the MSS Digest of Policy Actions; (2) investigate strategies for (a) preserving institutional memory, which would document the results of MSS resolutions and actions taken by the AMA in response to policies passed by the AMA HOD and (b) reporting this information to the original resolution authors and MSS assembly; and (3) that these changes, and the AMA-MSS resolutions process as a whole, be reevaluated in an AMA-MSS Governing Council report to be presented 3 years after the adoption of these recommendations.~~

VRC testimony was limited. Your Reference Committee thanks the Section Delegates for their report on the AMA House of Delegates transmittal queue and policy process. We agree that the recommendations of the report will help streamline processes within the MSS. Your Reference Committee recommends SD Report A be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(14) RESOLUTION 015 - SUPPORT OF COLLECTIVE BARGAINING

RECOMMENDATION A:

The second Resolve of Resolution 015 be amended by addition and deletion:

RESOLVED, that our AMA-MSS support the right of physicians and medical trainees to collectively bargain, ~~including~~ via non-disruptive and disruptive means–including, but not limited to, strikes, picketing, work slowdowns and stoppages, and tactics interfering with billing–, and support efforts to remove national, state, and local restrictions on strike action on physicians and medical trainees; and be it further

RECOMMENDATION B:

Resolution 015 be adopted as amended.

RESOLVED, that our AMA-MSS rescind 530.017MSS from the policy digest; and be it further

RESOLVED, that our AMA-MSS support the right of physicians and medical trainees to collectively bargain, including via disruptive means, and support efforts to remove national, state, and local restrictions on strike action on physicians and medical trainees; and be it further

RESOLVED, that our AMA-MSS support the development and implementation of collective bargaining units and the membership of physicians and medical trainees in said units at a national, state, and local level.

VRC testimony was supportive of the resolution. Your Reference Committee agrees with testimony that this resolution is novel and especially important for our MSS to have an internal stance on due to the anticipated A-24 House of Delegates report from the AMA Council on Ethics and Judicial Affairs on this same topic. We agree with testimony to amend the resolution to clarify non-disruptive and disruptive collective bargaining. Thus, your Reference Committee recommends Resolution 015 be adopted as amended.

(15) RESOLUTION 102 - RADIATION EXPOSURE COMPENSATION COVERAGE

RECOMMENDATION A:

A new Resolve clause be added to Resolution 102:

RESOLVED, that this resolution be immediately forwarded to our AMA House of Delegates.

RECOMMENDATION B:

Resolution 102 be adopted as amended.

RESOLVED, that our American Medical Association support continued authorization of federal radiation exposure compensation programs and expanded program eligibility to downwind individuals, communities, and tribes affected by the ongoing environmental harms of historic atomic weapons testing, including, but not limited to, residents of areas affected by the test of the first atomic bomb in New Mexico and uranium miners employed between 1942 through 1990.

VRC testimony was supportive of the resolution. Your Reference Committee agrees with testimony that the resolution is novel and timely as it addresses expansion of the Radiation Exposure Compensation Act (RECA) which is up for re-authorization. We agree with testimony to add an immediate forward clause because there is current legislation pending in the House of Representatives to be voted on in the fall. Immediately forwarding this resolution to the HOD A-24 Meeting will allow the AMA to act. Thus, your Reference Committee recommends Resolution 102 be adopted as amended.

(16) RESOLUTION 108 - ACA SUBSIDIES FOR UNDOCUMENTED IMMIGRANTS

RECOMMENDATION A:

The first Resolve of Resolution 108 be amended by addition and deletion:

RESOLVED, that our American Medical Association support federal and state efforts to provide~~ing~~ subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions ~~on the~~ to purchase Affordable Care Act (ACA) ~~marketplaces~~plans.

RECOMMENDATION B:

Resolution 108 be adopted as amended.

RESOLVED, that our American Medical Association support providing subsidies for undocumented immigrants to purchase health insurance, including by extending

eligibility for premium tax credits and cost-sharing reductions on the Affordable Care Act (ACA) marketplaces.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to clarify the ask to support federal and state efforts, as well as avoid any misinterpretation of the term “marketplaces” by changing the term to “plans.” We want to note that the resolution authors are supportive of this amendment on the VRC. Thus, your Reference Committee recommends Resolution 108 be adopted as amended.

(17) RESOLUTION 109 - TRIBAL DIALYSIS ACCESS

RECOMMENDATION A:

A <u>new Resolve clause be added</u> to Resolution 109:

<u>RESOLVED, that our AMA support federal and other efforts to plan, fund, and offer technical assistance for the development and expansion of accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities.</u>

RECOMMENDATION B:

Resolution 109 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association ask the Indian Health Service to offer a plan, agency expertise and technical assistance, and health-facilities funding to assist Tribes in expanding local dialysis services; and be it further

RESOLVED, that our AMA support reform of the IHS Loan Repayment Program to be eligible for repayment with a part-time, rather than full-time employment commitment to IHS and Tribal Health Programs; and be it further

RESOLVED, Our AMA support a nationwide AI/AN Medicare and Medicaid enrollment campaign coordinated by CMS and the IHS that funds insurance navigator programs at Tribal Health Programs.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the resolution is novel and impactful. We agree with testimony to add a fourth resolve clause to extend the spirit of this resolution to include all specialty care. Thus, your Reference Committee recommends Resolution 109 be adopted as amended.

(18) RESOLUTION 115 - CORRECTIONS TO THE MEDICARE PART C PAYMENT STRUCTURE

RECOMMENDATION A:

The first Resolve of Resolution 115 be <u>amended by deletion:</u>

~~**RESOLVED, that our AMA-MSS support efforts to strengthen and protect Traditional Medicare; and be it further**~~

RECOMMENDATION B:

Resolution 115 be <u>adopted as amended</u>.

RESOLVED, that our AMA-MSS support efforts to strengthen and protect Traditional Medicare; and be it further

RESOLVED, that our AMA-MSS support policies that reduce or eliminate overpayment of insurance companies under Medicare Part C including, but not limited to:

(1) Reforming risk adjustment models to use multiple years of diagnostic data as it pertains to assigning patients risk scores and/or determining payments granted to Medicare Part C plans;
(2) Altering the methodology for determining what diagnoses qualify for risk-adjustment to make it comparable between Medicare Part C and Traditional Medicare;
(3) Publicly reporting coding pattern differences between Medicare Part C plans and Traditional Medicare including subsequent contract-level risk adjustments;
(4) Reforming the benchmark payment rate system to reduce overall payment rates to insurers;
(5) Reforming the Quality Bonus Payment program to operate in a budget-neutral manner and concentrate on clinically important outcomes.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the first resolve is vague and the whereas clauses lack evidence of the effectiveness of Traditional Medicare alone. Additionally, this may unintentionally restrict the MSS from advocating on alternative payer models in the future. Therefore, we recommend deletion of the first resolve. We agree with testimony that the second resolve is novel and important to establish an internal MSS position, as Medicare is often discussed at the AMA House of Delegates level. Thus, your Reference Committee recommends Resolution 115 be adopted as amended.

(19) RESOLUTION 205 - SUPPORT FOR DOULA CARE PROGRAMS

RECOMMENDATION A:

The first Resolve of Resolution 205 be <u>amended by addition and deletion:</u>

RESOLVED, that our American Medical Association support access to continuous one-to-one emotional support provided by ~~doulas as~~

nonmedical support personnel, such as doulas, including for patients who are incarcerated or detained.

RECOMMENDATION B:

Resolution 205 be adopted as amended.

RESOLVED, that our American Medical Association support access to continuous one-to-one emotional support provided by doulas as nonmedical support personnel including for patients who are incarcerated or detained.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the resolution is novel and well-researched. We agree with testimony to recommend minor amendments based on feedback from the American College of Obstetricians and Gynecologists. We believe the amended language will garner more support in the HOD since it incorporates feedback from relevant specialty societies, while also maintaining, if not augmenting, the authors' original intent. Your Reference Committee recommends Resolution 205 be adopted as amended.

(20) RESOLUTION 207 - REPATRIATION OF AMERICAN INDIAN, ALASKA NATIVE, AND NATIVE HAWAIIAN REMAINS

RECOMMENDATION A:

The first Resolve of Resolution 207 be amended by addition and deletion:

RESOLVED, that our American Medical Association supports: (a) the expeditious return of American Indian, ~~and~~ Alaska Native, and Native Hawaiian anatomical remains, biospecimens, and cultural items from US medical schools to Tribal governments and Native Hawaiian cultural organizations in compliance with the Native American Graves Protection and Repatriation Act; (b) federal funds and ~~federal~~ technical assistance for inventory documentation and processing of repatriation claims; and (c) dissemination of best practices for affiliating remains with ancestral claimants.

RECOMMENDATION B:

Resolution 207 be adopted as amended.

RESOLVED, that our American Medical Association support: (a) the expeditious return of American Indian and Alaska Native anatomical remains, biospecimens, and cultural items from US medical schools to Tribal governments and Native Hawaiian cultural organizations; (b) funds and federal technical assistance for inventory documentation

and processing of repatriation claims; and (c) dissemination of best practices for affiliating remains with ancestral claimants.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to clarify the resolution by amending (1) clause a to include the Native Hawaiian population as they are covered under the Native American Graves Protection and Repatriation Act (NAGPRA), and (2) clause b by adding the word "federal" to clarify the source of the funds. We do not agree with amendments that ask the AMA to study best practices for affiliating remains with ancestral claimants because that study is outside the AMA's scope. Your Reference Committee recommends Resolution 207 be adopted as amended.

(21) RESOLUTION 211 - SSI SAVINGS PENALTY ELIMINATION

RECOMMENDATION A:

The first Resolve of Resolution 211 be <u>amended by addition and deletion:</u>

RESOLVED, that our American Medical Association support <u>appropriate</u> ~~increased~~ asset limits for <u>evidence based cash assistance programs such as</u> ~~for~~ Supplemental Security Income (SSI) ~~eligibility~~ that are indexed to inflation ~~moving forward~~ <u>or other equitable economic measures</u>; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 211 be <u>amended by addition and deletion:</u>

RESOLVED, that our AMA <u>study</u> ~~support~~ the establishment of individualized equivalent asset limit eligibility requirements for SSI benefits, regardless of marital status.

RECOMMENDATION C:

Resolution 211 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association support increased asset limits for Supplemental Security Income (SSI) eligibility that are indexed to inflation moving forward; and be it further

RESOLVED, that our AMA support the establishment of individualized equivalent asset limit eligibility requirements for SSI benefits, regardless of marital status.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the first resolve clause should be amended to allow for broader advocacy that is not limited to Supplemental Security Income (SSI). We agree with testimony that there is a lack of evidence to support the ask of the second resolve clause and recommend a study on establishing best practices for individualized equivalent asset limit eligibility requirements. Your Reference Committee recommends Resolution 211 be adopted as amended.

(22) RESOLUTION 223 - INCREASED TRANSPARENCY IN PSYCHOTROPIC DRUG ADMINISTRATION IN PRISONS

RECOMMENDATION A:

The first Resolve of Resolution 223 be amended by addition and deletion:

RESOLVED, that our American Medical Association study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness ~~physician and psychiatrist oversight~~; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 223 be amended by addition:

RESOLVED, that our AMA support increased transparency from state and federal jails and prisons surrounding protocols pertaining to the administration of psychotropic medications, including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.

RECOMMENDATION C:

Resolution 223 be adopted as amended.

RESOLVED, that our American Medical Association study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and physician and psychiatrist oversight; and be it further

RESOLVED, that our AMA support increased transparency from state and federal jails and prisons surrounding protocols pertaining to the administration of psychotropic medications.

VRC testimony was supportive. Your Reference Committee agrees with testimony that this resolution is well-researched and a study would be appropriate given limited data collection on the issue. An AMA study will investigate the extent of primary research available or not available, helping guide evidence-based policy recommendations and guidance. We agree with minor amendments to (1) update language in the first resolve clause to avoid inadvertently implying that psychiatrists are not physicians and (2) include desired components to support transparency in the second resolve clause. Your Reference Committee recommends Resolution 223 be adopted as amended.

(23) RESOLUTION 419 - EQUITY IN CELIAC DISEASE AND/ FOOD ALLERGIES RESEARCH AND RESOURCES

RECOMMENDATION A:

The first Resolve of Resolution 419 be amended by addition and deletion:

RESOLVED, that our American Medical Association support federal and state efforts to increase the affordability ~~lower the price~~ and quality of food alternatives for people with celiac disease, food allergies, and food intolerance~~of allergen- and gluten- free foods~~; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 419 be amended by addition and deletion:

RESOLVED, that our AMA support federal and state ~~policies~~efforts to extend requirements for mandatory nutrient fortification to food alternatives for people with celiac disease, food allergies, and food intolerance~~expand mandatory fortified nutrients to gluten-free food options~~; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 419 be amended by deletion:

~~RESOLVED, that our AMA support efforts to investigate food insecurity in families receiving SNAP benefits that have medical conditions, such as food allergies and/or celiac disease, that potentially increases vulnerability to food insecurity; and be it further~~

RECOMMENDATION D:

The fourth Resolve of Resolution 419 be amended by addition and deletion:

RESOLVED, that our AMA support efforts to ~~lower the income requirements for families with~~ expand nutrition assistance eligibility and benefits to equitably meet the needs of households affected by celiac disease, food allergies, and food intolerance~~food allergies and/or Celiac disease and provide additional Supplemental Nutrition Assistance Program (SNAP) benefits to already-qualified families~~ and increase access to food alternative for people with celiac disease, food allergies, and food intolerance, including but not limited to efforts by food banks and pantries, food delivery systems, and prescription produce programs.

RECOMMENDATION E:

Resolution 419 be adopted as amended.

RESOLVED, that our American Medical Association support efforts to lower the price of allergen- and gluten- free foods; and be it further

RESOLVED, that our AMA support federal and state policies to expand mandatory fortified nutrients to gluten-free food options; and be it further

RESOLVED, that our AMA support efforts to investigate food insecurity in families receiving SNAP benefits that have medical conditions, such as food allergies and/or celiac disease, that potentially increases vulnerability to food insecurity; and be it further

RESOLVED, that our AMA support efforts to lower the income requirements for families with food allergies and/or Celiac disease and provide additional Supplemental Nutrition Assistance Program (SNAP) benefits to already-qualified families.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the resolution is impactful and novel. We agree with testimony to amend the resolution to make the resolution more feasible and give the AMA room to advocate on this issue moving forward. We agree with testimony to clarify the language in the first resolve clause, make the second resolve clause more broad, strike the third resolve clause as it contradicts the resolution's ask, and broaden the ask of the fourth resolve to encompass future advocacy opportunities. Your Reference Committee recommends Resolution 419 be adopted as amended.

(24) RESOLUTION 422 - PROTECTING THE HEALTHCARE SUPPLY CHAIN FROM THE IMPACTS OF CLIMATE CHANGE

RECOMMENDATION A:

The first Resolve of Resolution 422 be amended by deletion:

~~**RESOLVED, that our American Medical Association support assessments of the vulnerability of existing healthcare supply chains in the context of climate change-related events; and be it further**~~

RECOMMENDATION B:

The second Resolve of Resolution 422 be amended by addition and deletion:

RESOLVED, that our AMA support the development of strategies and technologies to strengthen supply chain networks, including building climate resiliency into new or updated facilities, increasing emergency stockpiles of key products,~~relocating facilities to climate-resilient areas~~ and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances.

RECOMMENDATION C:

Resolution 422 be adopted as amended.

RESOLVED, that our American Medical Association support assessments of the vulnerability of existing healthcare supply chains in the context of climate change-related events; and be it further

RESOLVED, that our AMA support the development of strategies and technologies to strengthen supply chain networks, including relocating facilities to climate-resilient areas and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first resolve clause is not actionable as written. We believe the first resolve clause is broadly covered by existing policy H-440.847, and therefore more policy on this would not meaningfully change AMA advocacy efforts. We recognize and agree that the AMA is doing a lot of work on the issue of climate change, and that climate change is a timely issue. Your Reference Committee was unclear of what is considered a climate-resilient area, and our recommended amendments to the second resolve clause were created to make the ask more feasible. Your Reference Committee recommends Resolution 422 be adopted as amended.

Pandemic Preparedness H-440.847
In order to prepare for a pandemic, our AMA:
(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency;
(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti- microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency;
(3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;
(4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;
(5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;
(6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical

countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care provider;
(7) will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.
(8) will encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States.
(9) will support federal efforts to encourage the purchase of domestically produced personal protective equipment. [CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

(25) RESOLUTION 427 - AMA STUDY ON PLASTIC POLLUTION REDUCTION

RECOMMENDATION A:

The first Resolve of Resolution 427 be <u>amended by addition and deletion:</u>

RESOLVED, that our AMA-MSS amend 460.028MSS, "Research of Plastic Use in Medicine," which is pending submission to HOD, by addition and deletion as follows:

460.028 Research of Plastic Use in Medicine
~~Our AMA-MSS will ask the AMA to study~~ <u>Our AMA will study and report back with policy recommendations on ways to reduce plastic pollution and its impact on climate change and health, including but not limited to federal, state, and local taxes and limitations on the use of single-use plastic consumer products and other types of plastic, as well as interventions to reduce microplastics.</u>

~~AMA-MSS will ask the AMA to amend by addition as follows:~~
~~**Stewardship of the Environment H-135.973**~~
~~The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians~~

~~and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14)~~ encourages research into the effects of microplastics on human health~~; (15~~4) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (16~~5) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (17~~6) encourages expanded funding for environmental research by the federal government; and (18~~7) encourages family planning through national and international support.~~

RECOMMENDATION B:

Resolution 427 be adopted as amended.

RESOLVED, that our AMA-MSS amend 460.028MSS, "Research of Plastic Use in Medicine," which is pending submission to HOD, by addition and deletion as follows:

460.028 Research of Plastic Use in Medicine
Our AMA-MSS will ask the AMA to study ways to reduce plastic pollution and its impact on climate change and health, including but not limited to federal, state, and local taxes and limitations on the use of single-use plastic consumer products and other types of plastic, as well as interventions to reduce microplastics.

~~AMA-MSS will ask the AMA to amend by addition as follows:~~
~~**Stewardship of the Environment H-135.973**~~
~~The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages research into the~~

~~effects of microplastics on human health; (154) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (165) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (176) encourages expanded funding for environmental research by the federal government; and (187) encourages family planning through national and international support.~~

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the first resolve clause can be strengthened by asking for report back with policy recommendations. Your Reference Committee recommends Resolution 427 be adopted as amended.

(26) GC REPORT A – SUNSET REPORT

RECOMMENDATION A:

The third Resolve of GC Report A be amended by addition and deletion:

That our AMA-MSS amend 630.044MSS by addition and deletion as follows:

630.044MSS Review and Revision of the MSS Positions Compendium via the Sunset and Consolidation Mechanisms ~~for AMA-MSS Policy~~

AMA-MSS will establish and use a sunset mechanism for AMA-MSS ~~policies~~ positions with a ~~ten~~five-year time horizon whereby a ~~policy~~ position will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS ~~policy~~ position shall follow the following procedures:

(1) review of ~~policies~~ positions will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial ~~policy~~ position recommendations being solicited from relevant Standing Committees as appropriate;

(2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset;

(3) ~~policy~~ position recommendations will be reported to the AMA-MSS Assembly at each Annual Meeting on the ~~ten~~ five or fourfive

~~nine~~ and one-half year anniversary of a ~~policy's~~ position's adoption, with a brief rationale accompanying each recommendation;

(4) a consent calendar format will be used by the Assembly in considering the ~~policies~~ positions encompassed within the report;

(5) a vote will not be necessary on ~~policies~~ positions recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council; ~~and~~

(6) the MSS Governing Council ~~may~~ ~~will annually~~ should recommend ~~at least three~~ ~~policies for~~ consolidations of groups of related positions, whereby the report(s) are authored by the MSS Chair with recommendations solicited from relevant Standing Committees as appropriate;

(7) when MSS positions are reviewed via either the sunset or consolidation mechanisms, the result of any positions submitted to HOD and associated implementation actions will be reviewed and documented for archival purposes if not already characterized ~~as part of the sunset review process~~;

(8) in their report on the previous HOD's proceedings, the Section Delegates will recommend changes to any MSS positions that amend AMA Policy and were considered by HOD, in order to summarize the amendment's ask and simplify the language; and

(9) any MSS positions written as "MSS will ask the AMA" will be automatically converted to past tense ("asked the AMA") after consideration by HOD as either a resolution or an amendment; and

(10) any MSS position (or portion of a position) requesting an AMA or MSS study will automatically sunset after the study is completed by either the AMA or MSS or after consideration of the study request by HOD.

RECOMMENDATION B:

GC Report A be adopted as amended.

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report by filed:

1. That the recommendations for retention, retention including amendments, and consolidation actions specified in Appendix B, Appendix B, and Appendix C of this report be retained as official, active positions of the AMA-MSS or rescinded as indicated.
2. That the recommendations regarding MSS positions in Appendix A and Appendix B of this report be adopted.

3. That our AMA-MSS amend 630.044MSS by addition and deletion as follows:

630.044MSS Review and Revision of the MSS Positions Compendium via the Sunset and Consolidation Mechanisms ~~for AMA-MSS Policy~~

AMA-MSS will establish and use a sunset mechanism for AMA-MSS ~~policies~~ positions with a ten~~five~~-year time horizon whereby a ~~policy~~ position will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS ~~policy~~ position shall follow the following procedures:

(1) review of ~~policies~~ positions will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial ~~policy~~ position recommendations being solicited from relevant Standing Committees as appropriate;

(2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset;

(3) ~~policy~~ position recommendations will be reported to the AMA-MSS Assembly at each Annual Meeting on the ten ~~five~~ or ~~five~~ nine and one half year anniversary of a ~~policy's~~ position's adoption, with a brief rationale accompanying each recommendation;

(4) a consent calendar format will be used by the Assembly in considering the ~~policies~~ positions encompassed within the report;

(5) a vote will not be necessary on ~~policies~~ positions recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council; ~~and~~

(6) the MSS Governing Council ~~may~~ will annually recommend at least three ~~policies for~~ consolidations of groups of related positions, whereby the report(s) are authored by the MSS Chair with recommendations solicited from relevant Standing Committees as appropriate;

(7) when MSS positions are reviewed via either the sunset or consolidation mechanisms, the result of any positions submitted to HOD and associated implementation actions will be reviewed and documented for archival purposes if not already characterized ~~as part of the sunset review process~~;

(8) in their report on the previous HOD's proceedings, the Section Delegates will recommend changes to any MSS positions that amend AMA Policy and were considered by HOD, in order to summarize the amendment's ask and simplify the language; and

(9) any MSS positions written as "MSS will ask the AMA" will be automatically converted to past tense ("asked the AMA") after consideration by HOD as either a resolution or an amendment; and

(10) any MSS position (or portion of a position) requesting an AMA or MSS study will automatically sunset after the study is completed by either the AMA or MSS or after consideration of the study request by HOD.

VRC testimony was limited. Your Reference Committee thanks the MSS Governing Council for a comprehensive sunset and consolidation report. We agree with testimony sharing concerns of changing the sunset mechanism from 5 to 10 years, as we see the great potential of a loss of institutional memory and a loss of members who are experienced in sunset review resulting from this change in the timeline. Additionally, your Reference Committee agrees with testimony that mandating three consolidations per year is too prescriptive and could potentially result in inappropriate consolidations in the future that would perhaps unintentionally alter the spirit of original positions for the sake of reaching the directed quota. We would note that the MSS Governing Council previously studied the sunset mechanism and reported updates to the process via MSS GC Report A, 630.044MSS, at MSS A-23, and did not include this alteration to the timeline, nor included the requirements to the language regarding consolidation. Your Reference Committee amended this item to ask for the sunset review at the 5- and 4.5-year mark. The sunset review was moved from the Interim to Annual meeting in the last Sunset Report, so the new timing would allow sunset review to be in the same calendar year. Your Reference Committee recommends GC Report A be adopted as amended.

(27) GC REPORT J – USE OF INCLUSIVE LANGUAGE IN AMA POLICY

RECOMMENDATION A:

The first Resolve of GC Report J be amended by addition and deletion:

RESOLVED, that our American Medical Association, in consultation with relevant parties, including the AMA Center for Health Equity, amend existing policies ~~via the reaffirmation and sunset processes~~ to ensure the use of the most updated, inclusive, equitable, respectful, destigmatized, and person-first language and use such language in all future AMA policies and amendments; and be it further

RECOMMENDATION B:

GC Report J be amended by addition of a new Resolve:

RESOLVED, that our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, identify other types of outdated language in AMA policies and devise a timely mechanism for editorial changes, including both one-time updates and a protocol for editorial changes to language at the HOD Reference Committee recommendation stage and whenever a policy is amended, modified, appended, reaffirmed, or reviewed for sunset; and report back to the House of Delegates; and be it further

RECOMMENDATION C:

The second Resolve of GC Report J be amended by deletion:

~~**RESOLVED, that our AMA-MSS rescind 630.077MSS, "Inclusive Language for Immigrants in Relevant Past and Future AMA Policies," as it is superseded by the first resolve, and accordingly withdraw this resolution from our HOD submission queue.**~~

RECOMMENDATION D:

GC Report J be amended by addition of a new Resolve:

RESOLVED, that our AMA-MSS amend 630.041MSS, "Inclusion of AOA-Accredited Schools in Policy Language," by addition and deletion as follows:

> **630.041MSS Inclusion of Medical Students from AOA-Accredited Schools in MSS Resolutions and Positions ~~Policy Language~~**
>
> **~~It is the policy of t~~The AMA-MSS ~~that resolutions and internal policies~~ will specifically recognize ~~osteopathic students~~ medical students from schools accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) whenever appropriate in resolutions and internal MSS positions.**

RECOMMENDATION E:

GC Report J be adopted as amended.

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be filed:

RESOLVED, that our American Medical Association amend existing policies via the reaffirmation and sunset processes to ensure the use of the most updated, inclusive, equitable, respectful, destigmatized, and person-first language and use such language in all future AMA policies and amendments; and be it further

RESOLVED, that our AMA-MSS rescind 630.077MSS, "Inclusive Language for Immigrants in Relevant Past and Future AMA Policies," as it is superseded by the first resolve, and accordingly withdraw this resolution from our HOD submission queue.

VRC testimony was supportive with amendments. Your Reference Committee thanks the MSS Governing Council for their thoughtful report and agrees with testimony that the

resolution is novel. We agree that a broader stance will make the resolution more feasible for the AMA to act upon. Your Reference Committee recommends that the first resolve clause be amended to broader language that will apply even if language and terminology changes. We agree to strike the second resolve clause in order to leave the decision up to the Caucus withdrawal process headed by the Section Delegates. Your Reference Committee recommends GC Report J be adopted as amended.

(28) CEQM WIM LGBTQ+ REPORT A – COVERAGE FOR CARE PROVIDED AFTER SEXUAL ASSAULT

RECOMMENDATION A:

The first Resolve of GC Report A be <u>amended by addition and deletion:</u>

Your Committee on Economics and Quality in Medicine (CEQM) Women in Medicine Committee (WIM), and Committee on LGBTQ+ Affairs (LGBTQ+) recommend that the following recommendations are adopted in lieu of MSS Resolution 078 and the remainder of this report be filed:

RESOLVED, that the American Medical Association amend policy H-80.999 "Sexual Assault Survivors" by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing <u>and prevention, drug testing,</u> treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
<u>3.Our AMA advocates for federal and state efforts to reduce financial barriers that limit survivors' ability to seek physical and mental health care and social</u>

services after sexual assault, including survivors' compensation funds and specialized programs. These programs should at a minimum ~~to~~ cover emergency, acute inpatient, and ~~outpatient~~ follow up services, including testing, medications, and counseling. ~~and eliminate~~ This care should be provided with no out-of-pocket expenses~~,~~ for any patient, including ~~especially for~~ patients who are uninsured, underinsured, or out-of-network.

4. ~~3.~~ Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

5. ~~4.~~ Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

6. ~~5.~~ Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

7. ~~6.~~ Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

RECOMMENDATION B:

CEQM WIM LGBTQ+ Report A be adopted as amended.

Your Committee on Economics and Quality in Medicine (CEQM) Women in Medicine Committee (WIM), and Committee on LGBTQ+ Affairs (LGBTQ+) recommend that the following recommendations are adopted in lieu of MSS Resolution 078 and the remainder of this report be filed:

RESOLVED, that the American Medical Association amend policy H-80.999 "Sexual Assault Survivors" by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical

societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing and prevention, drug testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3.Our AMA advocates for federal and state efforts to reduce financial barriers that limit survivors' ability to seek physical and mental health care and social services after sexual assault, including survivors' compensation funds and specialized programs to cover emergency, inpatient, and outpatient services and eliminate out-of-pocket expenses, especially for patients who are uninsured, underinsured, or out-of-network.

4. ~~3.~~ Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

5. ~~4.~~ Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

6. ~~5.~~ Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

7. ~~6.~~ Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to clarify the language in clause three. Your Reference Committee thanks the authors for their work on this report and recommends CEQM WIM LGBTQ+ Report A be adopted as amended.

(29) LGBTQ+ CHIT REPORT A – IMPROVING USABILITY OF ELECTRONIC HEALTH RECORDS FOR TRANSGENDER AND GENDER DIVERSE PATIENTS

RECOMMENDATION A:

The first Resolve of GC Report A be amended by addition and deletion:

Your Committees on LGBTQ Affairs (LGBTQ+) and Committee on Health Information Technology (CHIT) recommend(s) that the recommendations be adopted in lieu of Resolution 072 and the remainder of this report be filed:

RESOLVED, that our American Medical Association amend policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows.

> **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967**
> **Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex-specific anatomy in medical documentation, and related forms, including in electronic health records (EHR), in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize the ~~or conceal~~ legal name except when required for ~~insurance and billing~~appropriate administrative purposes; (2) Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) Will advocate**

for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians; and be it further

RECOMMENDATION B:

LGBTQ+ CHIT Report A be <u>adopted as amended</u>.

Your Committees on LGBTQ Affairs (LGBTQ+) and Committee on Health Information Technology (CHIT) recommend(s) that the recommendations be adopted in lieu of Resolution 072 and the remainder of this report be filed:

RESOLVED, that our American Medical Association amend policy H-315.967 “Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation” by addition and deletion to read as follows.

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~, <u>sex assigned at birth</u>, current gender identity, <u>legal sex on identification documents</u>, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ <u>chosen</u> name, and clinically relevant, sex-specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner<u>, with efforts to improve visibility and awareness of transgender and gender diverse patients’ chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes;</u> (2) Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians; and be it further

RESOLVED, that our AMA supports the use of the term “chosen name” over “preferred name,” recognizing the value of the term “chosen name” to transgender and gender-diverse patients.

VRC testimony was limited. Your Reference Committee commends the LGBTQ+ Affairs and Health Information Technology Standing Committees for a well-researched report. We recognize the point made by VRC testimony regarding the use of the word “conceal”

in the first resolve clause and feel that the word “conceal”, nor any synonymous alternatives are necessary as this is covered under the “de-emphasize” portion of the sentence. Additionally, your Reference Committee agrees with testimony that “appropriate administrative purposes” is less prescriptive than specifying insurance and billing and avoids an unintentional limitation of the language. Overall, we recommend amendments to clarify terminology while maintaining the spirit of the ask. Your Reference Committee recommends LGBTQ+ CHIT Report A be adopted as amended.

(30) MIC CSI CAIA REPORT A – INCREASING ACCESS TO MEDICAL INTERPRETERS IN RESEARCH AND SUPPORT FOR INCREASED DIVERSITY IN GENETIC RESEARCH

RECOMMENDATION A:

The second Resolve of MIC CSI CAIA Report A be amended by addition and deletion:

RESOLVED, that our AMA encourage all Institutional and Research Review Boards to develop and publish transparent guidance and requirements for interpreter services for ~~on the~~ enrollment of medical and clinical research participants with Limited English Proficiency and Deaf or Hard of hearing people~~provide recommendations for interpreter services that meet their requirements~~; and be it further

RECOMMENDATION B:

The third Resolve of MIC CSI CAIA Report A be amended by deletion:

RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on “Informed Consent of Subjects Who Do Not Speak English (1995)” ~~encourage the creation of a federal standard upon which individual IRBs may base recommendations~~; and be it further

RECOMMENDATION C:

MIC CSI CAIA Report A be amended by addition of a new Resolve:

RESOLVED, that our AMA support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations.

RECOMMENDATION D:

MIC CSI CAIA Report A be adopted as amended.

Your Minority Issues Committee, Committee on Scientific Issues, and the Committee on American Indian Affairs recommend that the following recommendations be *adopted in lieu* of **Resolution 028**, The Use of Language Interpreters in Medical and Clinical Research, and the remainder of this report be filed:

1. RESOLVED, that our American Medical Association support the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes; and be it further
2. RESOLVED, that our AMA encourage all Institutional and Research Review Boards to develop and publish transparent guidance on the enrollment of medical and clinical research participants with Limited English Proficiency and provide recommendations for interpreter services that meet their requirements; and be it further
3. RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent of Subjects Who Do Not Speak English (1995)" encourage the creation of a federal standard upon which individual IRBs may base recommendations; and be it further

Your Minority Issues Committee, Committee on Scientific Issues, and the Committee on American Indian Affairs recommend that **Resolution 043,** Support for Increased Diversity in Genetic Research, *not be adopted*, and the remainder of this report be filed.

VRC testimony was supportive. Your Reference Committee recommends to amend the resolution to clarify language and separate the third resolve clause for feasibility. Your Reference Committee recommends MIC CSI CAIA Report A be adopted as amended.

(31) ATF REPORT – MSS ARCHIVES TASK FORCE REPORT

RECOMMENDATION A:

The fourth Resolve of ATF Report be amended by deletion:

~~**RESOLVED, that our AMA-MSS produce an annotated reference committee report indicating the final assembly outcome at each meeting; and be it further**~~

RECOMMENDATION B:

The fifth Resolve of ATF Report be amended by deletion:

~~**RESOLVED, that our AMA-MSS produce and maintain archives of notes on information gathered regarding other delegations stances on MSS items and actions taken by the MSS Caucus at HOD; and be it further**~~

RECOMMENDATION C:

The sixth Resolve of ATF Report be amended by deletion:

~~**RESOLVED, that our AMA-MSS explore opportunities to engage with the Journal of the AMA (JAMA); and be further**~~

RECOMMENDATION D:

The seventh Resolve of ATF Report be amended by deletion:

~~**RESOLVED, that our AMA-MSS pursue and promote efforts that encourage state to state collaboration within policy and advocacy; and be it further**~~

RECOMMENDATION E:

The ninth Resolve of ATF Report be amended by deletion:

RESOLVED, that our AMA-MSS develop and maintain a current membership archive accessible to MSS Staff, GC, and Regional Executive Councils that tracks local campus section leadership ~~and general membership~~ who consent to sharing their contact information; and be it further

RECOMMENDATION F:

The tenth Resolve of ATF Report be amended by deletion:

~~**RESOLVED, that our AMA-MSS develop and maintain a database of MSS alumni who consent to share their information to serve as resources for the MSS; and be it further**~~

RECOMMENDATION G:

ATF Report be amended by addition of a new Resolve:

RESOLVED, that our AMA MSS Archives Task Force will work with relevant stakeholders to outline recommendations for establishing collaborations

with JAMA and state to state policy and advocacy collaborations and report back to the MSS Assembly during their A-25 report.

RECOMMENDATION H:

ATF Report be adopted as amended.

RESOLVED, that our AMA-MSS maintain a MSS Positions Compendium containing (1) all current MSS positions, outcomes of resolutions that were sent to the AMA House of Delegates, and actions taken by the AMA as a result of AMA Policy originally proposed by the MSS and (2) a separate section for rescinded MSS positions with accompanying rationale for their rescission; and be it further

RESOLVED, that our AMA-MSS maintain a MSS Resolutions Archive that will include at minimum authorship information, links to the original resolution, final language adopted by the MSS, final language adopted by the HOD, links to the HOD Policy Finder, implementation notes regarding AMA actions, and links to media coverage resulting from the resolution; and be it further

RESOLVED, that our AMA-MSS report information to the original MSS resolution and/or report authors regarding outcomes of resolution forwarded to HOD and implementation of associated adopted AMA policy; and be it further

RESOLVED, that our AMA-MSS produce an annotated reference committee report indicating the final assembly outcome at each meeting; and be it further

RESOLVED, that our AMA-MSS produce and maintain archives of notes on information gathered regarding other delegations stances on MSS items and actions taken by the MSS Caucus at HOD; and be it further

RESOLVED, that our AMA-MSS explore opportunities to engage with the Journal of the AMA (JAMA); and be further

RESOLVED, that our AMA-MSS pursue and promote efforts that encourage state to state collaboration within policy and advocacy; and be it further

RESOLVED, that our AMA-MSS maintain a guide on how to cite resolutions and represent organized medicine involvement on CVs and residency application materials; and be it further

RESOLVED, that our AMA-MSS develop and maintain a current membership archive accessible to MSS Staff, GC, and Regional Executive Councils that tracks local campus section leadership and general membership who consent to sharing their contact information; and be it further

RESOLVED, that our AMA-MSS develop and maintain a database of MSS alumni who consent to share their information to serve as resources for the MSS; and be it further

RESOLVED, that our AMA MSS maintain an Archives Task Force which will continue to investigate strategies for (a) preserving institutional memory, (b) reporting this information to the MSS, and (c) monitor the implementation of changes adopted as a result of the A-24 Archives Task Force Report and will work with GC to report back to the MSS Assembly at I-24 and A-25.

VRC testimony was limited. Your Reference Committee agrees with testimony that the first resolve is a helpful update to MSS operations and will improve the policymaking process actions for MSS members.

We support the second resolve clause as written and support the broad terminology "authorship information" so that the parties implementing this report have more flexibility; we discussed that student contact information is likely to change as students move from medical school to residency, and encourages the parties implementing this report to consider avenues to address this potential stumbling block.

The third resolve is being implemented currently and we support codifying this moving forward.

We recommend deletion of the fourth resolve clause because staff currently writes a Summary of Actions report, which outlines the final outcomes of the items of business of Annual and Interim that is already viewable by all MSS members. We believe an additional annotated Reference Committee Report would require extensive time and effort that would not be significantly different from the existing Summary of Actions report.

We recommend deletion of the fifth resolve clause because notes on policy actions are sensitive and we believe these notes are best kept internally due to concerns that an open archive could be forwarded outside of MSS members, mistakenly or not, and have detrimental unintended consequences for our Section's relationships with other Sections.

We recommend deletion of the sixth resolve clause because the clause is too broad to be meaningful; the asks of this can be accomplished outside of the policymaking process.

We recommend deletion of the seventh resolve clause because we do not agree that state to state collaboration needs to be codified and that this initiative is currently being carried out by some MSS members and can be done more widely without a specific position on it.

We support the eighth resolve clause as the guide to citing resolutions and reports has already been created and we recommend to the parties implementing this resolve to post the guide on a public resource such as the MSS Microbrick.

We recommend amending the ninth resolve clause to remove the archive of all general membership contacts due to privacy concerns; although we understand the potential benefits of national and regional leadership having access to this information, we believe the Local Campus Section contacts are important for communication purposes, while maintaining the privacy rights of all MSS members.

We recommend deletion of the tenth resolve clause due to feasibility concerns; this resource would be almost impossible to keep accurate.

We support the eleventh resolve to maintain the MSS Archives Task Force. Lastly, we recommend an additional resolve to cover the asks of the stricken sixth and seventh resolve clauses to ask the ATF to consider JAMA and state advocacy in their new task force and include intentions regarding these in their task force report.

We believe additional time to work on these topics and consult appropriate parties will allow for more prescriptive and actionable guidance. We thank the Archives Task Force for their extensive work on this report. Your Reference Committee recommends ATF Report be adopted as amended.

(32) SCTF REPORT – MSS STANDING COMMITTEE TASK FORCE ANNUAL REPORT

RECOMMENDATION A:

The first Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS Governing Council (a) implement the recommendations adopted by the MSS Assembly from~~of~~ the Standing Committee Task Force to restructure the Standing Committee framework and leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance operational efficiency~~, and (d) report back on the status of report implementation by A-25~~; and be it further

RECOMMENDATION B:

The second Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS Governing Council (a) implement the Division structure organizing Standing Committees into divisions led by a singular division chair with the flexibility to appoint additional leaders to assist with coordinating resolution reviews, reports, and programming~~as~~

~~outlined in section 2.2, and (b) include the timeline and requirements for leadership selection as outlined by Section 2.6~~; and be it further

RECOMMENDATION C:

The third Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS Governing Council (a) restructure the existing ~~16~~ Standing Committees into the delineated structure below with flexibility for Standing Committees to create additional subcommittees as appropriate ~~into the proposed 8 Standing Committees as outlined by Section 1.2,~~ and (b) include a ~~the~~ timeline and requirements for leadership selection ~~as outlined by Section 2.6~~; and be it further

Division 1: Healthcare Systems & Quality (HSQ)
- **a) Committee on Health Economics & Coverage (CHEC)**
- **b) Committee on Humanism & Ethics in Medicine (CHEIM)**
- **c) Committee on Legislative Affairs (COLA)**

Division 2: Science, Technology, and Public Health (STAPH)
- **d) Committee on Public Health (CPH)**
- **e) Committee on Science & Technology (CST)**

Division 3: Health Equity & Medical Education (HEME)
- **f) Committee on Medical Education (CME)**
- **g) Committee on Gender & Sexual Health (CGSH)**
  - **i. Subcommittee on Women in Medicine**
  - **ii. Subcommittee on LGBTQ+ Affairs**
- **h) Committee on Health Justice (CHJ)**
  - **i. Subcommittee on Disability Affairs**
  - **ii. Subcommittee on Minority Affairs**
  - **iii. Subcommittee on Tribal Affairs**

RECOMMENDATION D:

The fourth Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair, who will appoint members to the committee based on applications demonstrating significant previous AMA experience, including, but not limited to, considering applications from former Governing Council and BOT members as well as current and former Councilors ~~as outlined by Section 1.2.5~~; and be it further

RECOMMENDATION E:

The fifth Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Impact, Policy, and Action (IMPACT) to serve as a group led by the MSS Section Delegates, to assist with resolution review responsibilities as needed, document HOD results and implementation actions related to MSS resolutions for the MSS archives, participate in the sunset and consolidation processes for MSS positions, and emphasize training for new MSS members ~~with an emphasis on training as outlined by Section 1.7~~; and be it further

RECOMMENDATION F:

The sixth Resolve of SCTF Report be amended by deletion:

~~RESOLVED, that the AMA-MSS Governing Council require that Standing Committees produce resolved clauses for reports that are recommended to be transmitted to the AMA House of Delegates and be it further~~

RECOMMENDATION F:

The eighth Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS Governing Council develop a leadership and membership review and recall system ~~as outlined in Section 4~~and outline this system in the I-24 report; and be it further

RECOMMENDATION G:

The ninth Resolve of SCTF Report be amended by addition and deletion:

RESOLVED, that the AMA-MSS follow the implementation plan outlined in a-g~~Section~~ 7 stating that the current Standing Committees will remain for the 2024-2025 term and the new timeline will begin in January of 2025 by selection of leadership for the 2025 - 2026 Division and Standing Committee Chairs, overlapping with the existing structure;

- **a) Following closure of councilor positions post-Interim, applications for Division Chairs and Committee Chairs will open allowing individuals to apply to both;**
- **b) Division Chairs will be determined by the Governing Council and outgoing Division Chairs similar to councilor positions;**

c) **Committee Chairs will be selected after Division Chairs are selection by new and outgoing Division Chairs, with endorsements from Governing Council and Standing Committee Leadership;**
d) **Standing Committee Chair-Elects and outgoing Standing Committee Leadership will determine Vice Chair positions for following year;**
e) **applications for Vice Chairs will open prior to Annual with decision before Annual;**
f) **Division and Standing Committee Chairs will be announced at Annual, and general Standing Committee members will be launched;**
g) **Vice Chairs and general Standing Committee members will be determined by new Division Chairs, Standing Committee Chairs, and Governing Council; and be it further**

RECOMMENDATION H:

SCTF Report be amended by addition of a new Resolve:

RESOLVED, that the MSS standing committees execute, at minimum, the following functions under the direction of the MSS Governing Council:

a) **Provide recommendations for the policies reviewed as part of the AMA-MSS sunset and consolidation mechanisms under the coordination of the MSS Chair, Vice Chair, and Section Delegates;**
b) **Assist in the resolution review process under the coordination of the Section Delegates and Vice Chair;**
c) **Host resolution onboarding twice a year led by appropriate Standing Committee leadership to ensure Standing Committee members are all adequately trained to review resolutions.**
d) **Author self-generated reports at their discretion, so long as reports requested by the MSS Assembly and/or MSS Governing Council are still completed on the appropriate timeline;**
e) **One report extension can be granted without question with further extensions will be granted upon approval of appropriate Governing Council members. This timeline will be shared with Assembly at the original deadline meeting;**
f) **Produce whereas clauses to facilitate the transfer of any adopted report and, if applicable, to MSS-sponsored resolutions submitted to the AMA House of Delegates**
g) **Monitor federal legislation, regulation, and litigation relating to their subject area and work with other MSS members and the MSS Governing Council to organize student-led advocacy efforts and request actions by AMA staff as appropriate;**

h) **Organize educational programming and advocacy initiatives as necessary and appropriate; and be it further**

i) **Author comments for AMA Council reports, as directed by the MSS Section Delegates; and be it further**

j) **Support the MSS Governing Council and Staff in tracking and publicizing outcomes and implementation of MSS authored items at the AMA House of Delegates in the Standing Committee area of expertise; and be it further**

RECOMMENDATION I:

SCTF Report be amended by addition of a new Resolve:

RESOLVED, that our MSS remove specific reference to the Committee on Long Range Planning (COLRP) from the MSS IOPs during its next scheduled revision, to allow for flexibility as our Standing Committee structure continues to evolve and prevent possible incongruence between the IOPs and future MSS practice, without compelling the MSS to maintain COLRP simply because it is outlined in the IOPs.

RECOMMENDATION J:

SCTF Report be adopted as amended.

Your MSS Standing Committee Task Force (SCTF) recommends that the following recommendations be adopted and the remainder of this report is filed:

RESOLVED, that the AMA-MSS Governing Council (a) implement the recommendations of the Standing Committee Task Force to restructure the Standing Committee framework and leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance operational efficiency, and (d) report back on the status of report implementation by A-25; and be it further

RESOLVED, that the AMA-MSS Governing Council (a) implement the Division structure as outlined in section 2.2, and (b) include the timeline and requirements for leadership selection as outlined by Section 2.6; and be it further

RESOLVED, that the AMA-MSS Governing Council (a) restructure the existing 16 Standing Committees into the proposed 8 Standing Committees as outlined by Section 1.2, and (b) include the timeline and requirements for leadership selection as outlined by Section 2.6; and be it further

RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair as outlined by Section 1.2.5; and be it further

RESOLVED, that the AMA-MSS Governing Council restructure the Committee on Impact, Policy, and Action (IMPACT) to serve as a group led by the MSS Section Delegates with an emphasis on training as outlined by Section 1.7; and be it further

RESOLVED, that the AMA-MSS Governing Council require that Standing Committees produce resolved clauses for reports that are recommended to be transmitted to the AMA House of Delegates and be it further

RESOLVED, that every Standing Committee leadership team develop a detailed strategic plan at the beginning of their terms; and be it further

RESOLVED, that the AMA-MSS Governing Council develop a leadership and membership review and recall system as outlined in Section 4; and be it further

RESOLVED, that the AMA-MSS follow the implementation plan outlined in Section 7 stating that the current Standing Committees will remain for the 2024-2025 term and the new timeline will begin in January of 2025 by selection of leadership for the 2025 - 2026 Division and Standing Committee Chairs, overlapping with the existing structure; and be it further

RESOLVED, that a new Standing Committee Task Force will be formed to review the functioning of the new structure and write an informational report regarding the progress of transitions at the I-25 meeting. They will also write a final report with any recommendations at the A-26 meeting; and be it further

RESOLVED, that the Standing Committee structure and functioning be reviewed on four-year intervals after the completion of the 2025-2026 task force with the next report due at A-30; and be it further

RESOLVED, that the AMA-MSS rescind 640.008MSS and 640.017MSS and amend 640.001MSS, 640.013MSS, and 640.014MSS as outlined in Appendix B.

VRC testimony was limited. Your Reference Committee recommends amendments to the first resolve clause to clarify that the recommendations adopted by the MSS Assembly will be implemented.

We recommend amendments to the second resolve clause to codify one Division chair per division with flexibility to add additional chairs as needed; we believe the Division chair role can be accomplished by one person, and that a high volume of Division leaders may unintentionally lead to increased confusion regarding proper communication channels.

We recommend specific restructuring of the Divisions and committees in the third resolve clause to allow the MSS Assembly to comment on the proposed structure. Your Reference Committee would like to note that the structure of the Divisions and

committees proposed was amended based on the standing committee feedback given during SCTF meetings and on the VRC.

We recommend amendments to the fourth resolve to clarify the role of the advisory group and the application process.

We recommend amendments to the fifth resolve clause to remove the reference to the body of the report and outline the role of IMPACT.

We recommend removal of the sixth resolve clause as it is encompassed in the proposed resolved clauses in Recommendation H.

We support the seventh resolve clause and believe the strategic planning process will help the focus of Standing Committees and prepare MSS members for higher leadership roles that use this same process.

We recommend amendments to the eighth resolve clause to specifically ask for a report back on the recall system in an I-24 report.

We recommend amendments to the ninth resolve clause to codify the implementation plan instead of referring to the body of the report.

We support the tenth resolve clause to report back on the progress of the Standing Committee restructuring and work of the new task force.

We support the eleventh resolve clause to add in a review of the Standing Committees every four years.

We recommend the addition of a new resolve clause to codify the policy functions of the Standing Committees; we believe functions a-j will be helpful to guide the work of the Standing Committees and outline their collaboration in the policy process.

We recommend the addition of a second new resolve clause to remove the instances of COLRP in the IOPs since the fourth resolve clause of this report restructures COLRP into an advisory group.

We support the twelfth resolve clause to update MSS positions based on the work of the task force.

We thank the Standing Committee Task Force for their extensive work on this report. Your Reference Committee recommends SCTF Report be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(33) RESOLUTION 004 - SUPPORTING COMMUNITY PHYSICIAN AND PARAMEDIC PARTNERSHIPS

RECOMMENDATION:

Substitute Resolution 004 be adopted in lieu of Resolution 004:

RESOLVED, that our American Medical Association support federal and state efforts to establish, expand, and provide coverage for community paramedic programs supervised by physicians especially in rural areas.

RESOLVED, that our American Medical Association support efforts to establish and expand physician-led community paramedicine programs; and be it further

RESOLVED, that our AMA support legislation, regulation and other efforts to require all health payers to cover community paramedicine services.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony that the resolution is novel as it addresses a niche aspect of emergency medicine. We agree with testimony to combine the asks into one clarified resolve clause. Your Reference Committee notes that the authors of the resolution are supportive of Substitute Resolution 004. Thus, your Reference Committee recommends Substitute Resolution 004 be adopted in lieu of Resolution 004.

(34) RESOLUTION 321 - HUMANISM IN ANATOMICAL MEDICAL EDUCATION

RECOMMENDATION:

Substitute Resolution 321 be adopted in lieu of Resolution 321:

RESOLVED, that our American Medical Association supports the incorporation of humanism in human anatomy education programs, including, but not limited to, time for HIPAA-compliant recognition of donor backgrounds, reflection, discussion, and feedback; and be it further

RESOLVED, that our AMA supports accommodations for learners' and donors' cultural observances surrounding the deceased when appropriate; and be it further

RESOLVED, that our AMA supports donor memorial ceremonies at centers that utilize cadaveric-based human anatomy education programs.

RESOLVED, that our American Medical Association supports the incorporation of humanism in human anatomy education programs, including, but not limited to, curricular time for reflection, discussion, feedback, and accommodations for learners' cultural observances surrounding the deceased; donor recognition ceremonies; and HIPAA-compliant recognition of donor backgrounds with students and trainees.

VRC testimony was supportive with amendments. Your Reference Committee agrees with testimony to amend the resolution and separate it into three resolve clauses to improve organization and clarity. We believe the substitute resolution addresses the resolution author's asks while strengthening the language. Thus, your Reference Committee recommends Substitute Resolution 321 be adopted in lieu of Resolution 321.

(35) RESOLUTION 423 - PREVENTING HEAT RELATED ILLNESS WITH APPROPRIATE HEAT RESPONSE STANDARDS

RECOMMENDATION:

Substitute Resolution 423 be <u>adopted in lieu of</u> Resolution 423:

RESOLVED, that our American Medical Association supports federal, state, and local efforts to use the most updated and evidence-based heat index formulas and other relevant factors to accurately estimate heat-related morbidity and mortality, proactively issue heat alerts, and improve implementation of response plans; and be it further

RESOLVED, that our AMA supports efforts to implement and fund comprehensive heat response plans and allow Federal Emergency Management Agency funds and resources to be used for heat response.

RESOLVED, that our American Medical Association support the timely implementation of updated heat index formulas to be used by the National Weather Service to better guide Weather Forecast Offices nationwide in deploying heat alert thresholds that correspond with the onset of significant heat-attributable health burden; and be it further

RESOLVED, that our AMA support policy efforts to consider vulnerable populations in heat response plans, including where to implement heat-reducing interventions such as cooling centers, energy assistance, and changes to the built environment, such as urban greenspace.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first resolve is outside of the AMA's scope and the second resolve is covered by a pending MSS transmittal. We agree with testimony to propose language that encompasses the spirit of the resolution, is within AMA's scope, and will allow for broad

advocacy on this topic. Thus, your Reference Committee recommends Substitute Resolution 423 be adopted in lieu of Resolution 423.

RECOMMENDED FOR NOT ADOPTION

(36) RESOLUTION 008 - ROUTINE PROVISION OF INFORMATION CONCERNING INSULIN COST-REDUCTION PROGRAMS

RECOMMENDATION:

Resolution 008 not be adopted.

RESOLVED, that our American Medical Association support the implementation of routine physician-to-patient education (in the form of printed and/or digital information) regarding cost-reduction program options for insulin therapy: 1) at diagnosis, 2) annually and/or when not meeting treatment targets, 3) when complicating factors develop, and 4) when transitions in life and care occur; and be it further

RESOLVED, that our AMA support efforts by specialty societies and other relevant stakeholders to create a standardized informational resource that is: 1) written in plain language, 2) available in printed or digital format, and 3) available in several languages, such that patients can make informed decisions regarding private cost-reduction programs for insulin products.

VRC testimony was opposed to the resolution. Your Reference Committee agrees with testimony that this resolution would not result in any further AMA advocacy because existing policies H-100.964 and H-110.984 impactfully ask the AMA to support affordability of insulin for patients. Additionally, the asks of this resolution are regarding physician-patient education, which is an educational programming objective rather than an advocacy issue that is more in the purview of the AMA. Furthermore, the resolution was shared with the Endocrinology Delegation, and they have expressed interest in working with the student authors to submit the resolution to AMA HOD with appropriate language changes as they see fit. We agree with testimony that this resolution can be introduced through the relevant specialty society. Your Reference Committee recommends Resolution 008 not be adopted.

(37) RESOLUTION 020 - SUPPORT FOR EARLY DETECTION AND INTERVENTION OF JUVENILE DEPRESSION

RECOMMENDATION:

Resolution 020 not be adopted.

RESOLVED, that our American Medical Association amend Policy H-60.937, “Youth and Young Adult Suicide in the United States,” as follows;

"Youth and Young Adult Suicide in the United States," H-60.937
1. Our American Medical Association recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Our AMA encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources.
3. Our AMA supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide.
4. Our AMA encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk.
5. Our AMA encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system.
6. Our AMA supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults.
7. Our AMA supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
8. Our AMA will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic.
9. Our AMA will advocate at the state and national level for policies by young adults mental, emotional, and behavioral health.
10. Our AMA will advocate for comprehensive system of care including prevention, management, and crisis care to address

mental and behavioral health needs for children, youth, and young adults.
11. Our AMA will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
12. Our AMA will recommend the use of the PHQ-9 in public schools to identify those who may be impacted by Depression or other mental illness.
13. Our AMA will provide access to a list of mental health providers and/or ways to access regional mental health providers to public schools, for recommended distribution by the school to any student who tests positive on the PHQ-9.

VRC testimony was opposed to the resolution. Your Reference Committee agrees with testimony that the whereas clauses do not contain enough evidence to support the implementation of PHQ-9 screening in all public schools. Additionally, we agree with testimony that the resolution is covered under existing policy H-345.977. Thus, your Reference Committee recommends Resolution 020 not be adopted.

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives. [Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18]

(38) RESOLUTION 021 - PHYSICIAN-LED AND RURAL ACCESS TO EMERGENCY CARE

RECOMMENDATION:

Resolution 021 <u>not be adopted.</u>

RESOLVED, that our AMA-MSS support access to emergency medical care led by Emergency Medicine-trained physicians, where possible, with appropriate exceptions for

rural and critical access health systems where their employment is likely to further compromise the systems' financial viability; and be it further

RESOLVED, that our AMA-MSS support physician-led emergency medical care with appropriate supervision for non-physician healthcare providers, which should include on-site or immediately available physician consultation.

VRC testimony was mainly opposed to the resolution as written. Your Reference Committee agrees with testimony that the whereas clauses do not provide enough evidence for the asks of this resolution. A similar resolution was proposed at I-23, triggering an AMA Board of Trustees (BOT) report on the requirements for on-site emergency physicians that is set to reach the House of Delegates at I-24. Your Reference Committee deliberated many strategic considerations posed on the VRC and we agree with testimony that this resolution needs more time to address scope of practice and actionability. We agree with testimony that this resolution as written could have unintended consequences such as limiting access to healthcare in rural areas. Given the complexity of the issue, your Reference Committee believes we need the information from the BOT report prior to taking a stance on requirements for on-site physicians in emergency departments. Thus, your Reference Committee recommends Resolution 021 not be adopted.

(39) RESOLUTION 022 - OPPOSITION TO CAPITAL PUNISHMENT

RECOMMENDATION:

Resolution 022 <u>not be adopted.</u>

RESOLVED, that our American Medical Association oppose all forms of capital punishment.

VRC testimony was supportive of the resolution. Your Reference Committee agrees with testimony that this resolution is novel and has a strong evidence base. We do not recommend adoption of this resolution because the Minority Affairs Section submitted the same resolution to the AMA HOD A-24 Meeting. The MSS has a current internal position opposing capital punishment as seen in 270.035MSS, rendering both an external and internal ask redundant. Thus, your Reference Committee thanks the authors for their work on this resolution and recommends Resolution 022 not be adopted.

(40) RESOLUTION 023 - IMPROVING IPV SCREENING FOR PEOPLE WITH DISABILITIES

RECOMMENDATION:

Resolution 023 <u>not be adopted.</u>

RESOLVED, that our American Medical Association study the prevalence of IPV in people with disabilities, currently available screening tools for IPV in people with disabilities, and the unique IPV-related issues faced by people with disabilities; and be it further

RESOLVED, that our AMA promote research into the validation, development, and implementation of improved evidence-based IPV screening that addresses the specific forms of abuse faced by people with disabilities; and be it further

RESOLVED, that our AMA support efforts to educate physicians regarding the importance of regular IPV screening for patients with disabilities using an evidence-based and validated disability-specific screening tool.

VRC testimony was opposed to the resolution. Your Reference Committee agrees with testimony that this resolution is covered under existing policy H-515.965. Thus, we agree with testimony that this resolution will not meaningfully change AMA's advocacy efforts. Additionally, as mentioned in the whereas clauses, the Abuse Assessment Screen-Disability _AAS-D) already exists and has higher accuracy than traditional screening tools, therefore, AMA advocacy efforts may not result in meaningful change. Your Reference Committee recommends Resolution 023 not be adopted.

> Family and Intimate Partner Violence H-515.965
> (1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
> (2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and

disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:
(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. [CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19]

(41) RESOLUTION 203 - ACCESS TO HEALTHCARE FOR TRANSGENDER AND GENDER DIVERSE INCARCERATED PEOPLE

RECOMMENDATION:

Resolution 203 <u>not be adopted.</u>

RESOLVED, that our American Medical Association advocate for readily accessible gender affirming care to meet the distinct healthcare needs of transgender and gender diverse individuals who are incarcerated, including but not limited to evaluations for gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay.

VRC testimony was opposed to the resolution. Your Reference Committee agrees with testimony that the AMA has strong policy supporting access to Gender Affirming Care and the resolution will not change AMA advocacy efforts. We agree with testimony that this resolution is covered under H-185.927, H-430.982, and H-430.986. Your Reference Committee recommends Resolution 203 not be adopted.

Clarification of Evidence-Based Gender-Affirming Care
Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between

the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.

Our AMA will work with state and specialty societies and other interested stakeholders to: advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence; oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care; support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.

Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers. [Res. 05, A-16; Modified: Res. 015, A-21; Modified: Res. 223, A-23; Appended: Res. 304, A-23]

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.

2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement. [BOT Rep. 24, A-18]

Health Care While Incarcerated H-430.986

Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance

programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.

Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

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

Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.

Our AMA supports:

linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and

improve health outcomes among this vulnerable patient population, as well as adequate funding;
the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and
collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
knowledge of the health disparities among individuals who are involved with the criminal justice system.
Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

(42) RESOLUTION 213 - UNDOCUMENTED WORKER PROTECTIONS

RECOMMENDATION:

Resolution 213 not be adopted.

RESOLVED, that our AMA-MSS support awareness of abuse in undocumented workers and the development of health-related interventions, such as occupational safety trainings and provisions of workplace safety equipment; and be it further

RESOLVED, that our AMA-MSS support Medicare expansion to undocumented workers through removal of immigration status as eligibility criteria.

VRC testimony was split between support and opposition to the resolution as written. Your Reference Committee agrees with testimony that the evidence presented in the whereas clauses is not enough to support the asks of the resolution. We agree with testimony that the first resolve clause is not actionable as supporting awareness is not a clear advocacy effort. Additionally, the second resolve clause is unlikely to result in meaningful advocacy at this time. Your Reference Committee recommends Resolution 213 not be adopted.

(43) RESOLUTION 308 - EXPANDING MEDICAL EDUCATION ACCESS AND SUPPORT FOR FIRST-GENERATION STUDENTS

RECOMMENDATION:

Resolution 308 not be adopted.

RESOLVED, that our American Medical Association collaborate with appropriate stakeholders, such as the AAMC, to increase population-specific supportive measures for first-generation students throughout medical school; and be it further

RESOLVED, that our AMA amend Policy H-200.951, “Strategies for Enhancing Diversity in the Physician Workforce,” as follows:

Strategies for Enhancing Diversity in the Physician Workforce, H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, ~~and~~ rurality, and first-generation status; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially

and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

VRC testimony was opposed to the resolution. Your Reference Committee appreciates the spirit of the resolution, but we agree with testimony that the first resolve clause is covered under existing policy H-200.951 and would not result in intended additional advocacy. We agree with testimony on the second resolve clause that opening up previously passed AMA policy to amendments and discussion given current DEI controversies may result in unintended consequences. Your Reference Committee further reviewed the late testimony provided by the authorship team, and while we appreciate the efforts by the authors to strengthen this resolution, we do not believe that the new ask was supported by the whereas clauses. Thus, your Reference Committee recommends Resolution 308 not be adopted.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed

programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21]

(44) RESOLUTION 311 - PARITY FOR DO AND MD GRADUATING SENIORS THROUGH REPORTING TOTAL NUMBER OF DO AND MD APPLICANTS INTERVIEWED AND RANKED BY EACH RESIDENCY PROGRAM

RECOMMENDATION:

Resolution 311 <u>not be adopted.</u>

RESOLVED, that our American Medical Association partner with Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine, and other appropriate stakeholders to require all residency programs to report the number of DO and MD applicants they interview and rank as part of the NRMP Annual Report.

VRC testimony was opposed to the resolution. Your Reference Committee agrees with testimony that this resolution is covered under existing policy D-310.977. Since the resolution is not novel, we agree that the resolution will not result in meaningful advocacy. Your Reference Committee recommends Resolution 311 not be adopted.

National Resident Matching Program Reform D-310.977
Our AMA:

(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the

implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process. [CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22]

(45) RESOLUTION 313 - OPPOSITION TO MEDICAL SCHOOL ADMISSIONS PREFERENCE FOR CHILDREN OF DONORS AND FACULTY

RECOMMENDATION:

Resolution 313 not be adopted.

RESOLVED, that our American Medical Association recognize that relation to donors may be one reason, among many, for an applicant to express interest in a particular school, but otherwise oppose consideration of donor relations in the evaluation of medical school applicants due to its discriminatory impact on the diversity of the physician workforce; and be it further

RESOLVED, that our AMA work with the Association of American Medical Colleges (AAMC) and American Association of Colleges of Osteopathic Medicine (AACOM) to deemphasize the consideration of donor relation status in medical school admissions; and be it further

RESOLVED, that our AMA work with AAMC, AACOM, or other relevant stakeholders to investigate the prevalence and impacts of faculty relation status in medical school admissions.

VRC testimony was mainly opposed to the resolution as written. We agree with testimony that there is not a clear delineation between donor status and legacy status. Your Reference Committee discussed that donor status and legacy status may be two distinct entities but may also be related in certain instances. Your Reference Committee agrees with testimony that the resolution is covered under existing policy H-295.845. Since H-295.845 was recently adopted at A-23, we do not believe the introduction of

more policy will result in meaningful AMA advocacy efforts at this time. Thus, your Reference Committee recommends Resolution 313 not be adopted.

> Against Legacy Preferences as a Factor in Medical School Admissions H-295.845
> Our American Medical Association recognizes that legacy status may be one of many stated reasons an applicant may offer for interest in a particular medical school, but opposes the use of questions about legacy status in the medical school application process due to their discriminatory impact. [Res. 309, A-23]

(46) RESOLUTION 315 - REMOVING HEADSHOT REQUIREMENTS FROM MEDICAL SCHOOL, RESIDENCY, AND FELLOWSHIP APPLICATIONS

RECOMMENDATION:

Resolution 315 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support discontinuing the headshot requirement from all medical school, residency program, and fellowship applications, and be it further

RESOLVED, that our AMA support blinding selection committees to all applicant's photographs prior to granting interviews in instances where discontinuation of headshot requirements proves unattainable.

VRC testimony was mainly opposed to the resolution as written. The Reference Committee agrees with concerns that the resolution lacks sufficient evidence to support the resolve clauses. Additionally, we agree with testimony that the resolution does not address unintended consequences of the resolve clauses as written. Thus, your Reference Committee recommends Resolution 315 not be adopted.

(47) RESOLUTION 402 – STUDYING THE EFFECTS OF PLANT-BASED MEAT

RECOMMENDATION:

Resolution 402 <u>not be adopted.</u>

RESOLVED, that our AMA-MSS edit the pending transmittal titled "Support for Research on the Nutritional and Other Impacts of Plant-Based Meat" as follows:

> "RESOLVED, that our American Medical Association <u>study the health-related effects of consuming</u> ~~work with appropriate parties to support~~ plant-based <u>and lab-grown</u> meat ~~research funding~~."

VRC testimony was split. Your Reference Committee agrees with testimony that the MSS A-22 report titled "Advocating for Plant-Based Meat Research and Regulation," which performed a literature review on plant-based meat, concluded that there was limited data available on this subject. Therefore, we believe requesting an AMA study is not the appropriate advocacy avenue on this subject. We believe the AMA should work with appropriate stakeholders to support research bodies in their efforts on plant-based meat data collection. Your Reference Committee recommends Resolution 402 not be adopted.

(48) RESOLUTION 403 – IMPROVING CHILD DISCIPLINARY EDUCATION FOR CAREGIVERS

RECOMMENDATION:

Resolution 403 not be adopted.

RESOLVED, that our American Medical Association collaborate with the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, Centers for Disease Control, and other relevant organizations to develop novel culturally-concordant "how-to-discipline children" educational resources and programs that are centralized online in multiple languages to be offered to caregivers by the 6 month well child visit without cost; and be it further

RESOLVED, that our AMA work with the relevant specialty societies to develop a standardized CME training on AMA Ed Hub for residents and physicians.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with testimony that the resolution is covered under H-515.995, and therefore will not meaningfully impact AMA advocacy efforts. Your Reference Committee recommends Resolution 403 not be adopted.

(49) RESOLUTION 404 – SUPPORT FOR STANDARDIZED PERIODIC HEARING SCREENINGS IN PRIMARY SCHOOLS

RECOMMENDATION:

Resolution 404 not be adopted.

RESOLVED, that our American Medical Association support periodic hearing screenings in children based on evidence-based guidelines, including a national recommendation for the development of standardized periodic hearing screenings in primary schools with appropriate referral to a physician for a comprehensive audiologic evaluation.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with testimony that the whereas clauses do not establish a strong evidence base. We agree with testimony that the asks of the resolution will not significantly changes AMA's advocacy efforts. The American Academy of Pediatrics already has detailed guidelines regarding hearing screenings in children, and expanding these recommendations would be within the purview of specialty societies. Your Reference Committee recommends Resolution 404 not be adopted.

(50) CME CDA REPORT A – STUDYING EFFECTS OF ONLINE EDUCATION ON MEDICAL EDUCATION OUTCOMES DURING COVID-19 PANDEMIC

RECOMMENDATION:

CME CDA Report A <u>not be adopted.</u>

Your Committee on Medical Education and Committee on Disability Affairs recommend that the following recommendations are adopted in lieu of and the remainder of this report is filed:

RESOLVED, that our AMA study the impact of curricular structure including distance learning and third-party educational resources in undergraduate medical education on knowledge- and behavioral-based core competencies of medical education and student mental health.

VRC testimony was mixed. The Reference Committee agrees with testimony that an AMA study on this topic is not impactful. We agree with testimony that the asks of the resolution will not significantly change AMA's advocacy efforts by asking the AMA to do a literature review. Your Reference Committee discussed amendments proposed on the VRC in length, but ultimately decided on our recommendation to not adopt due to the existence of ChangeMedEd and their experimental and innovative work and ongoing studies on undergraduate medical education. We feel that AMA policy on this issue would not result in a meaningful outcome or addition to the work that is already underway. Your Reference Committee recommends CME CDA Report A not be adopted.

(51) WIM COLA LGBTQ+ REPORT A – ADDRESSING GENDER-BASED DISPARITIES ON HEALTH-RELATED CONSUMERGOODS (THE PINK TAX)

RECOMMENDATION:

WIM COLA LGBTQ+ Report A <u>not be adopted.</u>

Your Women in Medicine Committee, Committee on Legislation & Advocacy, and Committee on LGBTQ+ Affairs, recommend(s) that the following recommendation is adopted in lieu of Resolution 049 and the remainder of this report be filed:

RESOLVED, that our American Medical Association support federal and state efforts to minimize gender-based pricing disparities.

VRC testimony was supportive. However, while this report provided further gender disparities in consumer goods, the Reference Committee agrees that the questions of scope and feasibility posed to the Standing Committees were not addressed in this report. Additionally, the single ask resulting from this report is too broad and the body of the report has provided little substantive evidence for the effectiveness of the ask. Your Reference Committee recommends WIM COLA LGBTQ+ Report not be adopted.

RECOMMENDED FOR FILING

(52) GC REPORT B – MSS ACTION ITEM UPDATE REPORT

RECOMMENDATION:

GC Report B be filed.

Your MSS Governing Council recommends GC Report B be filed.

The Reference Committee thanks the MSS Governing Council for a comprehensive report on the status of MSS Action Items submitted since the MSS Interim 2023 Meeting. Your Reference Committee recommends GC Report B be filed.

(53) SD REPORT B – POLICY PROCEEDINGS OF THE INTERIM 2023 HOUSE OF DELEGATES MEETING

RECOMMENDATION:

SD Report B be filed.

Your Section Delegates recommend GC Report B be filed.

The Reference Committee thanks the MSS Section Delegates for a comprehensive report on the actions of the MSS Interim 2023 Meeting. Your Reference Committee recommends SD Report B be filed.