MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

Edward H. Dench, MD

Introduced by Jill Owens, MD, Pennsylvania Chair; James D. Grant MD MBA FASA, American Society of Anesthesiologists

Whereas, Edward H. Dench, MD, of State College, Pennsylvania, born on August 18, 1945, in Philadelphia, Pennsylvania and departed this life on May 9, 2024, at the age of 78, leaving behind a legacy of great dedication and service; and

Whereas, Dr. Dench, lived a life marked by passion and commitment to medicine, aviation, and his community, embodying the virtues of perseverance and thoughtfulness in every aspect of his personal and professional life; and

Whereas, Dr. Dench's academic journey began with his graduation from Penn State University with a B.S. in Aerospace Engineering was followed by an M.D. from the University of Pennsylvania, and continued with a residency at the University of Pennsylvania Hospital; and

Whereas, Dr. Dench's love of Aerospace Medicine led him to the Navy, where he served as a Naval Flight Surgeon and earned the Navy & Marine Corps Medal for daring rescue of a Marine in Kauai; and

Whereas, Dr. Dench served the surrounding State College area as Anesthesiologist and Aviation Medical Examiner for 40 years; and

Whereas, Dr. Dench championed a peer review system for doctors analogous to aviation reporting, prioritizing learning and transparency; and

Whereas, nationally recognized for his leadership, Dr. Dench held influential positions at the Pennsylvania Medical Society, PA Society of Anesthesiologists, and as a recurrent delegate for both the AMA and American Society of Anesthesiologists; and

Whereas, Dr. Dench is survived by his wife Valerie Dench of State College, PA, 5 children and 1 stepchild (Darla, Lana, Edward III, Erin, Robert, and Vanessa), 8 grandchildren, and 3 siblings; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Edward H. Dench's passing with a moment of silence; and be it further

RESOLVED, that our American Medical Association record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Edward H. Dench.

George R. Green, MD

Introduced by Jill Owens, MD, Pennsylvania Chair; Steve Tolber, MD, American Academy of Allergy, Asthma and Immunology Delegate

Whereas, George R. Green, MD, of Lafayette Hill, Pennsylvania, born on October 14, 1934, in Philadelphia, Pennsylvania and departed this life on January 28, 2024, at the age of 89, leaving behind a legacy of profound dedication, service, and compassion; and

Whereas, Dr. Green, lived a life marked by exceptional contributions to medicine, education, and the community, embodying the virtues of humility, perseverance, and kindness in every aspect of his personal and professional life; and

Whereas, Dr. Green's academic journey, marked by his graduation from the University of Pennsylvania School of Medicine with Alpha Omega Alpha honors, and furthered by his internship and residency at the Hospital of the

University of Pennsylvania and the Mayo Clinic respectively, and a fellowship in Allergy and Immunology at the University of Pennsylvania, set a foundation for a career that would impact countless lives; and

Whereas, Dr. Green dedicated over 50 years of service at Abington Memorial Hospital, where he specialized in Internal Medicine and Allergy and Immunology, founding Abington Medical Specialists and serving in numerous leadership roles, including as the Chief of the Division of Allergy and Immunology, Chairman of the Medical Education Committee, and Medical Staff President, thereby significantly advancing the field of healthcare; and

Whereas, nationally recognized for his leadership, Dr. Green held influential positions in the American Academy of Allergy, Asthma and Immunology, the American Medical Association, the Pennsylvania Medical Society, and the Montgomery County Medical Society, recognized as a steadfast patient advocate and a consistent champion of small specialties and independent private practice, as well as quality healthcare; and

Whereas, Dr. Green's scholarly contributions, including seminal research on penicillin hypersensitivity and authorship of pivotal texts, have left an indelible mark on the field of Allergy and Immunology, contributing to the betterment of patient care and medical knowledge; and

Whereas, his commitment to graduate medical education as a volunteer clinical faculty member and Professor of Medicine at the Hospital of the University of Pennsylvania, mentoring countless medical students, residents, and fellows, reflects his unwavering dedication to nurturing the next generation of physicians; and

Whereas, Dr. Green combined medicine with aviation by serving as a FAA medical examiner, volunteering for Angel Flights providing air transportation to those in need, and serving as president of the northeast chapter of Flying Physician Association; and

Whereas, Dr. Green is survived by his wife Trudy Green of Lafayette Hill PA, 4 children (George Jr, Trudy, Matthew, and David) and 8 grandchildren; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Green's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. George R Green.

Jeffrey Kaufman, MD, FACS
Introduced by American Association of Clinical Urologists,
American Urological Association

Whereas, Dr. Jeffrey Kaufman was not only a gifted Urologic Surgeon and a tireless physician's advocate for organized medicine, he also served our AMA as Delegate of the American Association of Clinical Urologists from 2008-2014; and

Whereas, Jeffrey received his undergraduate degree with honors from UCLA before obtaining his M.D. from the University of Southern California. After two years of training in general surgery, he completed his urology residency at the University of California, San Diego. Following a pediatric urology fellowship at Children's Hospital of Michigan, he returned to Orange County, California where he began his private practice in general urology with a teaching affiliation at the University of California, Irvine. Over the past 34 years, he developed a deep interest in the socioeconomic and health policy aspects of urology and participated in several leadership roles; and

Whereas, Dr. Kaufman served as president of the American Association of Clinical Urologists, president of the Western Section AUA, Chief of Staff at Western Medical Center-Santa Ana, president of the Orange County Urological Society, president of the California Urologic Association, and as a member of the UROPAC Board of Directors; and

Whereas, Dr. Kaufman was awarded the AUA's Distinguished Service Award for decades of outstanding leadership and service to the AUA's Western Section, the AUA Board of Directors and health policy advocacy; and

Whereas; Jeffrey leaves behind his wife Linda of 47 years, daughters Jennifer & Lindsay, and grandchildren Ezra, Aaron, Isla, Kaia, and Bodhi. His family writes: “This dear man, with such a passion for life, who did everything to the fullest extent, and had an impact on so many, will be deeply missed”; therefore be it

RESOLVED, that our American Medical Association House of Delegates recognize the many contributions made by Dr. Jeffrey Kaufman to the medical profession as well as the Urological community; and be it further

RESOLVED, that our American Medical Association House of Delegates express its sympathy for the passing of Dr. Kaufman to his family and present them with a copy of this resolution.

Craig Kliger, MD
Introduced by the California Medical Association

Whereas, Craig Kliger, MD, was a respected colleague who served patients and his profession as a Delegate to the American Medical Association since 1985, serving on the Council on Ethical and Judicial Affairs during his residency, and was recently appointed to the AMA CPT Editorial Board for his expertise in coverage, payment, and coding issues; and

Whereas, Dr. Kliger served as a dedicated Trustee and Delegate to the California Medical Association and is known for his decade-long leadership on CMA’s Council on Medical Services where he guided the association through many difficult medical practice issues; and

Whereas, Dr. Kliger was a fellowship trained cornea specialist who devoted his career to advocacy, becoming one of the rare physicians to lead a professional society as the Executive Vice President of the California Academy of Eye Physicians and Surgeons (CAEPS) for eighteen years where he championed the profession and patient safety; and

Whereas, Dr. Kliger was honored by the American Academy of Ophthalmology many times including receiving the highest level of recognition in 2022 - the Outstanding Advocate Award – for his gifts as a writer, strategist, and leader who grew the state society and its PAC, developed an effective overall advocacy and key contact program, and built coalitions that culminated in the defeat of a major scope of practice expansion against surgical privileges for optometrists in the California Legislature; and

Whereas, Dr. Kliger was instrumental in establishing the Shulman Fellowship program in 2006 where every ophthalmology residency program in California would send young ophthalmologists to participate in the American Academy of Ophthalmology Congressional Advocacy Day which built a strong legacy of advocacy among ophthalmologists to protect patients and the profession; He also expanded public education in California and continuing medical education for ophthalmologists; and

Whereas, Dr. Kliger was widely recognized for his ability to work through complex issues in a fair manner, such as using his extensive knowledge and expertise in coding and reimbursement issues to actively engage with third-party payers and Noridian, the Medicare Contractor, to protect physician practices and patient access to medical care; and

Whereas, Dr. Craig Kliger, MD passed away on April 16, 2024, at the young age of 62 and will be missed for his dry sense of humor, attention to detail and organization, tenacity, and tireless leadership to protect patients and improve the profession for all physicians; therefore be it

RESOLVED, That our American Medical Association express the utmost respect for Craig Kliger, MD, and honor his legacy of advocacy and devotion to patients, and the profession he loved and served with dedication.

Robert E. McAfee, MD

Introduced by Richard A. Evans, MD, Delegate, and Maroulla Gleaton, MD, Delegate on behalf of the Maine Delegation

Whereas, Robert E. McAfee MD, passed away on December 16, 2023, in Portland, Maine;

Whereas, Dr. McAfee was a general and vascular surgeon who practiced in Portland, Maine, his hometown. He received his B.S. degree from Bates College and his M.D. degree from Tufts University School of Medicine in 1960. Dr. McAfee completed his internship and surgical residency at the Maine Medical Center (MMC) in 1965, and was attending surgeon at MMC for 31 years as well as Chief of Surgery and Vascular Surgery at Mercy Hospital; and

Whereas, Dr. McAfee was elected President-Elect of the American Medical Association (AMA) in June 1993 and served as the 149th President of the AMA from June 1994 to June 1995. Long active in organized medicine, Dr. McAfee was past president of the Maine Medical Association and the Cumberland County Medical Society, and held many leadership roles; and

Whereas, Dr. McAfee served as Vice Chair of the AMA's Board of Trustees from 1990 to 1992 and was a member of the Executive Committee of the Board from 1988 to 1992. He served as an AMA Commissioner to the Joint Commission on Accreditation of Healthcare Organizations from 1986 to 1992 and was President of the AMA Education and Research Foundation from 1986 to 1988; and

Whereas, Dr. McAfee took an active role in community, state and national health care issues, focusing his attention on family violence. He was appointed to the American Bar Association's Commission on Domestic Violence; served on the Advisory Committee to the Attorney General and the Secretary of the Department of Health and Human Services in the Clinton administration; was a member of the Center for Disease Control and Prevention Advisory Committee for Injury Prevention and Control and its Subcommittee on Violence; served on the National Advisory Committee of the Family Violence Defense Fund and was the founding chair of the Physician's Coalition Against Family Violence representing twenty three physician specialty organizations; and

Whereas, Dr. McAfee received several honorary degrees and many awards including the Maine Medical Association's 2022 President's Award for Distinguished Service, and in 2012 was recognized by the Daniel Hanley Center for Health Leadership for his "lifetime of extraordinary leadership in Maine and the nation"; and therefore be it

RESOLVED, that the House of Delegates recognize Dr. McAfee's passing with a moment of silence; and be it further

RESOLVED, that this resolution be recorded and presented to Dr. McAfee's family.

Edith P. Mitchell, MD

Introduced by Jill Owens, MD, Pennsylvania Chair; AMA Minority Affairs Section, National Medical Association; Steve Young Lee, MD, FACP, Association for Clinical Oncology (ASCO) Delegation Chair

Whereas, Edith P. Mitchell, MD, FCPP, FRCP, MACP, born on November 20, 1947, in Brownsville, Tennessee and departed this life unexpectedly on January 21, 2024, at the age of 76, leaving behind a legacy of profound compassion, trailblazing, and impact; and

Whereas, Dr. Mitchell, lived a life marked by exceptional contributions to innovation, equity, and the community, embodying the virtues of determination, excellence, and compassion in every aspect of her personal and professional life; and

Whereas, Dr. Mitchell's academic journey, marked by her graduation from the Medical College of Virginia (now Virginia Commonwealth University) as the only black female in attendance, furthered by her service to the United States Air Force, and followed by an internship and residency in internal medicine at Meharry Medical College,

simultaneously a member of Alpha Kappa Alpha, set a foundation for a career that would impact the practice of medicine and countless lives; and

Whereas, Dr. Mitchell's early career at the University of Missouri led her to be awarded the 1991 Distinguished Service Award, and was followed by her work to provide safe drinking water and hepatitis vaccine administration which led to her appointment in 1993 as the Missouri Surgeon General and later the first black female to be promoted to Brigadier general in the Missouri Air National Guard; and

Whereas, Dr. Mitchell joined the faculty of medicine and medical oncology as associate director of Diversity Programs for the Sideny Kimmel Comprehensive Cancer Center at Thomas Jefferson University in Philadelphia, PA, after retiring from the United States Air Force, where she conducted research into pancreatic cancer that led to innovative care including new drug evaluation, chemotherapy, and therapeutic regimens; and

Whereas, Dr. Mitchell's work at Thomas Jefferson University was commemorated with numerous awards including the American Cancer Society Cancer Control Award, National Medical Association Council on Concerns of Women Physicians Pfizer Research Award, Physician of the Year by CancerCare, Practitioner of the Year from Philadelphia County Medical Society, and the Distinguished Service Award from the Pennsylvania Medical Society; and

Whereas, Dr. Mitchell's relentless pursuit to eliminate health disparities, expand minority participation in clinical trials, and improve care for her patients led her to establish the Center to Eliminate Cancer Disparities within Jefferson, present advice and opinions to the Congressional Black Caucus, and later serve on President Biden's Cancer Moonshot Initiative panel; and

Whereas, Dr. Mitchell served the American Medical Association proudly as a National Medical Association Delegate; and

Whereas, Dr. Mitchell dutifully served as the National Medical Association Representative on the AMA Minority Affairs Section Governing Council from June 2016 to June 2019; and

Whereas, Dr. Mitchell is predeceased by her husband, Delmar, and survived by her two daughters; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Mitchell's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Edith P. Mitchell.

John Neeld, MD

Introduced by American Society of Anesthesiologists, Medical Association of Georgia

Whereas, Dr. Neeld was a revered and dedicated member of the medical community, known for his unwavering commitment to excellence, compassionate care, and leadership; and

Whereas, Dr. Neeld as a distinguished anesthesiologist in private practice, whose skilled hands and compassionate demeanor brought comfort and healing to countless patients over the years; and

Whereas, Dr. Neeld served with unparalleled devotion as President of the American Society of Anesthesiologists and the Chair of the Anesthesiology section council at the American Medical Association (AMA), where his leadership was instrumental in shaping policies and initiatives that advanced the field of anesthesiology and improved patient care nationwide; and

Whereas, Dr. Neeld also served as the Chair of AMPAC, demonstrating exceptional leadership in advocating for the interests of physicians and patients; and

Whereas, Dr. Neeld leaves behind a legacy of professionalism, integrity, and dedication that will continue to inspire and guide us all; therefore be it

RESOLVED, that our American Medical Association honor the memory of Dr. Neeld and express our deepest gratitude for his invaluable contributions to the field of medicine; and be it further

RESOLVED, that his legacy live on in the hearts and minds of all who had the privilege of knowing him, and may his spirit of excellence and compassion continue to inspire future generations of physicians.

Donald E. Parlee, MD
Introduced by Jill Owens, MD, Pennsylvania Chair; Virginia Hall, MD;
AMA Delegate and Chair of the Foundation of the Pennsylvania Medical Society

Whereas, physicians lost a beloved mentor and dedicated leader of our profession in the passing of Donald E. Parlee, MD, on March 21, 2024; and

Whereas, Dr. Parlee earned his medical degree from the Lewis Katz School of Medicine at Temple University in 1959 and completed his residency in diagnostic radiology at the University of Pennsylvania Health System in 1963; and

Whereas, Dr. Parlee enjoyed a 43-year career as a board-certified radiologist at Doylestown Hospital where he helped to grow the hospital's radiology department from one to 20 radiologists, serving as its chief for 25 years, and established its School of Radiologic Technology where he was fondly known for his gentle teaching style; and

Whereas, Dr. Parlee was a recognized physician leader and held prominent positions including President and then Secretary of the Bucks County Medical Society, Vice Chair of the Foundation of the Pennsylvania Medical Society, decades as Delegate to the Pennsylvania Medical Society, and, for 10 years, PAMED Delegate to the American Medical Association; and

Whereas, Dr. Parlee served as volunteer trustee for The Foundation of the Pennsylvania Medical Society for 13 years and generously supported its mission through his relationship with the Eden Charitable Foundation; and

Whereas, for his steadfast advocacy for physicians and patients, Dr. Parlee received the R. William Alexander MD Award for grassroots and political advocacy from the Pennsylvania Medical Political Action Committee; and

Whereas, from 1966-1968, Dr. Parlee served his country in Vietnam as a radiologist for the U.S. Army, earning him a Bronze Star; and

Whereas, Dr. Parlee's legacy will endure through his renowned generous philanthropy to charities for healthcare, education, and nature, as well as his esteemed leadership; therefore be it

RESOLVED, that our American Medical Association recognizes the outstanding contributions of Donald E. Parlee, MD, to the profession of medicine with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and that the AMA extend condolences to his wife Joan and their family.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Saturday, June 10. The following resolutions were dealt with on the reaffirmation calendar: 203, 211, 240, 241, 311, 413, 431, 713, 715.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

1. USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-460.962

RESOLVED, that our American Medical Association monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout

RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve professional workforce wellbeing.

2. REMOVAL OF THE INTERIM MEETING RESOLUTION COMMITTEE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association remove the Resolution Committee from Interim Meetings by amending AMA Bylaw B-2.13.3, "Resolution Committee," by deletion as follows:

~~**Resolution Committee. B-2.13.3**~~
~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~
~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~
~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~
~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~
~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~
~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications~~
~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~
~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented~~

~~to the House of Delegates at the call of the Speaker. (Modify Bylaws); and be it further~~

RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1, "Business of Interim Meeting," by deletion as follows:

~~**2.12.1.1 Business of Interim Meeting** The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.~~

3. AMENDMENTS TO AMA BYLAWS TO ENABLE MEDICAL STUDENT LEADERSHIP CONTINUITY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-605.985

RESOLVED, that our American Medical Association modify the current 90-day post-graduation eligibility provisions in AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation and not extending past the Annual Meeting following graduation.

4. THE RIGHTS OF NEWBORNS THAT SURVIVE ABORTION
Introduced by Thomas W. Epps, MD, Delegate

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association amend the current policy right for an abortion to "a woman's right to abortion as only the right to terminate the pregnancy";

RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical care.

5. AMA EXECUTIVE VICE PRESIDENT
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties and Privileges Code B-5.3.6.4 as follows:

~~No individual who has served as an AMA officer or trustee shall be selected or serve as Executive Vice President until three years following completion of the term of the AMA office."~~

6. TREATMENT OF FAMILY MEMBERS
Introduced by Missouri

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association asks CEJA to review and revise the current code of ethics as it relates to treating family members (Directive to Take Action)

RESOLVED, that our AMA ask CEJA to report back to the HOD on this issue at the next interim meeting I-24.

7. AMA SUPPORTS A STRATEGY FOR ELIMINATING NUCLEAR WEAPONS
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: POLICY D-440.972, H-520.988, H-520.994 and H-520.999 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association calls for the United States to renounce the option to be the first country to use nuclear weapons ("first use") during a conflict

RESOLVED, that our AMA supports a process whereby multiple individuals, rather than solely the President, are required to approve a nuclear attack, while still allowing a swift response when needed

RESOLVED, that our AMA calls on the US government to cancel plans to rebuild its entire nuclear arsenal and instead to reassess its true strategic needs for the types and numbers of nuclear weapons and delivery systems

8. CONSOLIDATED HEALTH CARE MARKET
Introduced by Barbara L. McAneny, MD, Delegate

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policy D-405.966

RESOLVED, that our American Medical Association investigate the possibility of filing a class action lawsuit against Optum, United Health Group and Change Health to recoup the damages from the disruption caused by the breach, and to distribute the unfair enrichment profits made by Optum et al to the practices whose retained payments allowed them to generate interest and investment profits.

RESOLVED, that our AMA investigate the acquisition of practices by Optum in the aftermath of the breach and determine if the independence of those practices can be resurrected, and if not, if damages are due to the physician owners of the acquired practices.

9. UPDATING LANGUAGE REGARDING FAMILIES AND PREGNANT PERSONS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-65.977

RESOLVED, that our American Medical Association review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures.

RESOLUTION 10 WAS WITHDRAWN

RESOLUTION 11 WAS WITHDRAWN

12. ETHICAL PRICING PROCEDURES THAT PROTECT INSURED PATIENTS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-110.982

RESOLVED, that our American Medical Association advocate for policies that limit the cost of a medications or durable medical equipment to an insured patient with coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer's free discount card (such as GoodRx);

RESOLVED, that our AMA write a letter to lawmakers and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients.

13. ETHICAL IMPETUS FOR RESEARCH IN PREGNANT AND LACTATING INDIVIDUALS
Introduced by American College of Obstetricians and Gynecologists

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-140.949

RESOLVED, that our American Medical Association Council on Ethical and Judicial Affairs consider updating its ethical guidance on research in pregnant and lactating individuals.

14. THE PRESERVATION OF THE PRIMARY CARE RELATIONSHIP
Introduced by New England

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-140.948

RESOLVED, that our American Medical Association opposes health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care

RESOLVED that our AMA requests the Council on Ethical and Judicial Affairs review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists

RESOLVED, that our AMA advocates for policies that promote patient choice, ensure continuity of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives.

15. HEALTH AND RACIAL EQUITY IN MEDICAL EDUCATION TO COMBAT WORKFORCE DISPARITIES
Introduced by New England

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-65.976

RESOLVED, that our American Medical Association engage partners to track the prevalence of attending physicians' and trainees' dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities;

RESOLVED, that our AMA engage partners to study and report back how to effectively support underrepresented groups in medicine to level the playing field for those most affected by bias and historical harms;

RESOLVED, that our AMA work with partners to make recommendations on a review and appeals process that will enable physicians and trainees to receive a fair and equitable due process in defense of alleged shortcomings.

16. GUIDING PRINCIPLES FOR THE HEALTHCARE OF MIGRANTS
Introduced by New York

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED**
See Policy H-65.938

RESOLVED, that our American Medical Association advocate for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement";

RESOLVED, that our AMA recognizes that migration status is a social determinant of health;

RESOLVED, that our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration;

RESOLVED, that our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families;

RESOLVED, that our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard;

RESOLVED, that our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by

1. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
2. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
3. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
4. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
5. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.

17. ADDRESSING THE HISTORICAL INJUSTICES OF ANATOMICAL SPECIMEN USE
Introduced by New York

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: **ADOPTED AS FOLLOWS**
ADDIITONAL RESOLVE REFERRED
See Policy H-140.820

RESOLVED, that Our American Medical Association advocate to AAMC (Association of American Medical Colleges), AACOM (American Association of Colleges of Osteopathic Medicine),and other appropriate bodies for the return of human remains to living family members or Tribes in the case of American Indian/Alaska Native specimens, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven, with Tribal consultation in the case of American Indian/Alaska Native specimens to ensure that all Tribal burial protocols are followed;

RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments, as required by laws such as the Native American Graves and Repatriation Act, and that our AMA encourage advocacy for federal funds and technical assistance for repatriation;

RESOLVED, that our AMA recognize the disproportionate impact that anatomical specimen collections have had on American Indian, Hawaiian, Alaska Native, Black American, individuals with disabilities, and other historically marginalized groups;

RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of Black and Brown people and other minority groups, and return remains and skeletal collections to living family members, or, if none exist, then respectful burial of anatomical specimens or remains;

RESOLVED, that Our AMA seek legislation or regulation that requires the return of anatomic specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups;

RESOLVED, that Our AMA support the creation of a national anatomical specimen database that includes registry demographics;

RESOLVED, that our AMA study and develop recommendations regarding regulations for ethical body donations including, but not limited to guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue;

RESOLVED, that our AMA believes that, for purpose of differentiation and clarity, anatomical specimens, tissues and other human material that were collected and maintained for purposes of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed consent for such has been obtained, and that biospecimens donated for research, education, and transplantation where informed consents of donors (or if deceased, next of kin if available) for such has been obtained, as such materials can advance medical knowledge, improve the quality of healthcare and save lives.

[Editor's note: The following resolve was referred]

RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors should be amended as follows:

> Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:
> (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
> (b) Has been developed in consultation with the population among whom it is to be carried out.
> (c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
>
> ~~Unless there are data that suggest a positive effect on donation, n~~ Neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

18. OPPOSING VIOLENCE, TERRORISM, DISCRIMINATION, AND HATE SPEECH
Introduced by New York

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policies D-65.975 and H-65.937

RESOLVED, that our American Medical Association strongly condemns all acts of violence, terrorism, discrimination, and hate speech against any group or individual, regardless of race, ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other factor;

RESOLVED, that our AMA affirms its commitment to promoting dialogue, empathy, and mutual respect among diverse communities, recognizing the importance of fostering understanding and reconciliation;

RESOLVED, that our AMA recognizes the importance of commemorating and honoring the victims of tragedies throughout human history, in a manner that respects the dignity and sensitivities of all affected communities;

RESOLVED, that our AMA encourages initiatives that promote education, awareness, and solidarity to prevent future acts of violence and promote social cohesion;

RESOLVED, that our AMA acknowledges the diverse perspectives and experiences within its membership and commits to facilitating constructive dialogue and engagement on sensitive and polarizing issues;

RESOLVED, that our AMA calls for continued collaboration and partnership with organizations representing diverse communities.

19. SUPPORTING THE HEALTH OF OUR DEMOCRACY
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-65.936

RESOLVED, that our American Medical Association support policies that ensure safe and equitable access to voting and opposes the institutional barriers to ~~both~~ the process of voter registration;

RESOLVED, that our AMA encourage physicians and medical trainees to vote, eliminate barriers to their participation in the electoral process, and support their and other healthcare workers' engagement in all voter registration efforts in healthcare settings, including emergency absentee ballot procedures for qualifying patients, visitors, and healthcare workers;

RESOLVED, that our AMA support the use of independent, nonpartisan commissions to draw districts for both federal and state elections.

20. VOTER PROTECTIONS DURING AND AFTER INCARCERATION
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policies H-65.935 and D-65.974

RESOLVED, that our American Medical Association support the continuation and restoration of voting rights for citizens currently or formerly incarcerated, support efforts ensuring their ability to exercise their vote during and after incarceration, and oppose efforts to restrict their voting rights;

RESOLVED, that our AMA research the impact of disproportionate policing in and incarceration of minoritized communities on voter participation and health outcomes;

RESOLVED, that our AMA develop educational materials and programming to educate medical trainees and physicians on the impact of incarceration on voting and health outcomes.

21. OPPOSITION TO CAPITAL PUNISHMENT
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policy H-140.896

RESOLVED, that our American Medical Association amend H-140.896, "Moratorium on Capital Punishment," by addition and deletion as follows:

Opposition to ~~Moratorium on~~ Capital Punishment H-140.896
Our AMA: (1) opposes all forms of ~~does not take a position on~~ capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process.

RESOLUTION 22 WAS WITHDRAWN

23. CHANGE HEALTHCARE SECURITY LAPSE—THE FBI MUST INVESTIGATE
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

Resolved, that our American Medical Association seek a directed investigation by appropriate authorities of the Change Healthcare cybersecurity breach that defines the cause, so as to minimize the chance of a future breach, as well as to determine any penalties for negligence, should that be a factor in the current episode;

Resolved, that our American Medical Association monitor all ongoing investigations of the Change Healthcare cybersecurity breach with report back at Interim 2024, with recommendations as to further action the AMA itself should pursue

24. AUGMENTED INTELLIGENCE AND ORGANIZED MEDICAL STAFF
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policies H-225.940 and H-225.957

Resolved, that our American Medical Association modify policy H-225.957, "Principles for Strengthening the Physician-Hospital Relationship," by addition:

> 1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

Resolved, that our AMA recognizes that organized medical staff should be an integral part at the outset of choosing, developing and implementing augmented intelligence and digital health tools in hospital care. That consideration is consistent with organized medical staff's primacy in overseeing safety of patient care, as well as assessing other negative unintended consequences such as interruption of, or overburdening, the physician in delivery of care.

25. THE HRSA – ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN) MODERNIZATION INITIATIVE
Introduced by American Society of Transplant Surgeons

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policies D-370.979 and H-370.953

RESOLVED, that our American Medical Association affirm that the Health and Resources and Services Administration's (HRSA) proposed changes to the Organ Procurement and Transplantation Network (OPTN) should not replace the existing public-private partnership between HRSA and the OPTN, and the OPTN should be maintained as a membership organization;

RESOLVED, that our AMA support an Organ Procurement and Transplantation Network (OPTN) Board, per the National Organ Transplant Act (NOTA) regulations, that includes patients, living donors and donor families, transplant centers, organ procurement organizations (OPOs), patient and medical associations, and other transplant stakeholders to ensure experience, expertise, and knowledge from content experts; and should be elected by the membership rather than be appointed or elected by the government or its contractors which would result in politicizing medical care decisions;

RESOLVED, that our AMA proactively advocate to the general public and encourage legislators and regulators to modernize the transplant system in a transparent, equitable, and efficient manner within the structure outlined in National Organ Transplant Act (NOTA).

REFERENCE COMMITTEE A

101. INFERTILITY COVERAGE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-185.990 and H-350.944

RESOLVED, that our American Medical Association amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows; and be it further

102. MEDICAID & CHIP BENEFIT IMPROVEMENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-185.972, H-185.929, H-330.872

RESOLVED, that our American Medical Association amend H-185.929 Hearing Aid Coverage by addition as follows; and be it further

103. MEDICARE ADVANTAGE PLANS
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-330.867

RESOLVED, that our American Medical Association encourage that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.

RESOLVED, that our AMA provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs.

104. MEDICAID ESTATE RECOVERY REFORM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid.

105. MEDIGAP PATIENT PROTECTIONS

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ALTERNATE RESOLUTION 105 ADOPTED IN LIEU OF RESOLUTIONS 105 AND 111
See Policy H-330.866

RESOLVED, that our American Medical Association support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans; and be it further

RESOLVED, that our AMA extend advocacy efforts to ensure federal "guaranteed issue" protections are enacted, allowing beneficiaries the freedom to switch from Medicare Advantage to Traditional Medicare plans without facing prohibitive barriers; and be it further

RESOLVED, that our AMA advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act for commercial insurance plans; and be it further

RESOLVED, that our AMA support efforts to expand access to Medigap plans to all individuals who qualify for Medicare benefits; and be it further

RESOLVED, that our AMA support efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries.

106. INCORPORATING SURVEILLANCE COLONOSCOPY INTO THE COLORECTAL CANCER SCREENING CONTINUUM
Introduced by American Society for Gastrointestinal Endoscopy

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: RESOLUTION 106 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 118
See Policy H-185.960

RESOLVED, that our American Medical Association Policy H-185.960, "Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans" be amended by addition to read as follows:

107. REQUIRING GOVERNMENT AGENCIES TO CONTRACT ONLY WITH NOT-FOR-PROFIT INSURANCE COMPANIES
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association advocate that government-owned health agencies such as Medicare and Medicaid be required to contract only with not-for-profit insurance companies or cooperatives; and be it further

RESOLVED, that our AMA support that those not-for-profit insurance companies or cooperatives receiving public revenues must allocate profits to reserves, investments in improving the quality of care in the system, or returned in the form of lower premiums for patients or the health agency.

108. REQUIRING PAYMENTS FOR PHYSICIAN SIGNATURES
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate that insurance companies be required to pay a physician for any required physician signature and/or peer to peer review which is requested or required outside of a patient visit.

109. COVERAGE FOR DENTAL SERVICES MEDICALLY NECESSARY FOR HEMATOLOGY AND ONCOLOGY CARE
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-320.936

RESOLVED, that our American Medical Association supports that oral examination and dental services prior to and following the administration of radiation, chemotherapy, immunotherapy, stem cell transplantation, cell and gene therapies, surgery, and high-dose bone-modifying agents for the treatment of hematologic and oncologic disorders are part of medically necessary care; and be it further

RESOLVED, that our AMA will advocate that all public and private payers cover medically necessary oral examination and dental services prior to the administration of and resulting as a complication of radiation, chemotherapy, immunotherapy, stem cell transplantation, cell and gene therapies, surgery, and high-dose bone-modifying agents, for all hematologic and oncologic disorders.

110. COVERAGE FOR SHOES AND SHOE MODIFICATIONS FOR PEDIATRICS PATIENTS WHO REQUIRE LOWER EXTREMITY ORTHOSES
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED
See Policy H-185.911

RESOLVED, that our American Medical Association support coverage by all private and government insurance companies for pediatric footwear suitable for use with lower extremity orthoses and medically necessary shoe modifications.

111. PROTECTIONS FOR "GUARANTEE ISSUE" OF MEDIGAP INSURANCE AND TRADITIONAL MEDICARE
Introduced by Ohio

Resolution 111 was considered with Resolution 105.
See Resolution 105.

RESOLVED, that our American Medical Association pursue all necessary legislative and administrative measures to ensure that Medicare beneficiaries have the freedom to switch back to Traditional Medicare and obtain Medigap insurance under federal "guaranteed issue" protections.

112. PRIVATE AND PUBLIC INSURANCE COVERAGE FOR ADAPTIVE SPORTS EQUIPMENT INCLUDING PROSTHESES AND ORTHOSES
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED
See Policy H-90.961

RESOLVED, that our American Medical Association recognizes activity-specific adaptive sports and exercise equipment as assistive devices that are integral to the health maintenance of persons with disabilities in accordance with national exercise guidelines; and be it further

RESOLVED, that our AMA recognizes activity-specific adaptive sports and exercise equipment, such as activity-specific prostheses and orthoses, as medical devices that facilitate independence and community participation; and be it further

RESOLVED, that our AMA advocate for coverage by all private and public insurance plans for activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities in order to promote health maintenance and chronic disease prevention.

113. SUPPORT PRESCRIPTION MEDICATION PRICE NEGOTIATION
Introduced by New England

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support pharmaceutical price negotiation for all prescription medications, both Medicare and private insurance; and be it further

RESOLVED, that our AMA advocate for any medication price that is raised by a pharmaceutical company more than the rate of inflation be immediately subject to price negotiation in the following year's negotiation schedule; and be it further

RESOLVED, that our AMA support extending the cap on annual out of pocket prescription drug spending in Medicare Part D plans to all insurance plans.

114. BREAST CANCER SCREENING/CLINICAL BREAST EXAM COVERAGE
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: NOT ADOPTED

RESOLVED, that our AMA advocate for Medicare coverage of clinical breast exams for all female and at-risk male patients during the Medicare Annual Wellness Visit (AWV) and Subsequent Annual Wellness Visit (SAWV) appointments.

115. PAYMENTS BY MEDICARE SECONDARY OR SUPPLEMENTAL PLANS
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-330.865

RESOLVED, our American Medical Association will advocate for legislation that would mandate that all health plans cover Medicare secondary claims regardless of the provider participating in the secondary health plan.

116. INCREASE INSURANCE COVERAGE FOR FOLLOW-UP TESTING AFTER ABNORMAL SCREENING MAMMOGRAPHY
Introduced by Texas

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED
See Policy H-185.910

RESOLVED, that our American Medical Association support public and private payer coverage for screening mammography and follow-up testing after an abnormal screening mammography; and be it further

RESOLVED, that our AMA advocate for legislation that ensures adequate funding for mammography services and follow-up testing after an abnormal screening mammography; and be it further

RESOLVED, that our AMA promote health care community education and public awareness of services provided for women of low income.

117. INSURANCE COVERAGE FOR GYNECOLOGIC ONCOLOGY CARE
Introduced by Texas

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association support efforts to include gynecologic oncologists alongside other types of oncologists in network adequacy standards and requirements for public and private plans, including the Centers for Medicare & Medicaid Services standards.

118. PUBLIC AND PRIVATE PAYER COVERAGE OF DIAGNOSTIC INTERVENTIONS ASSOCIATED WITH COLORECTAL CANCER SCREENING AND DIAGNOSIS
Introduced by Texas

Resolution 118 was considered with Resolution 106.
See Resolution 106.

RESOLVED, that our American Medical Association advocate (through legislation and/or regulation, as appropriate) for adequate payment and the elimination of cost sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy with a "diagnostic" intervention (i.e., the removal of a polyp or biopsy of a mass) and follow-up colonoscopy after a positive stool-based test.

REFERENCE COMMITTEE B

201. RESEARCH CORRECTING POLITICAL MISINFORMATION AND DISINFORMATION ON SCOPE OF PRACTICE
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: AMENDED AS FOLLOWS
See Policy D-405.968

RESOLVED, that our American Medical Association perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice; and be it further

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the A-25 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice.

202. USE OF ARTIFICIAL INTELLIGENCE AND ADVANCED TECHNOLOGY BY THIRD PARTY PAYORS TO DENY HEALTH INSURANCE CLAIMS
Introduced by American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED FOR REPORT BACK AT I-24

[Editor's Note: Resolution 202 was considered with BOT 15 and Resolution 246 which were also referred for report at I-24.]

RESOLVED, that our American Medical Association adopt as policy that Commercial third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health plans ensure they are making medical necessity determinations based on the circumstances of the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that does not account for an individual's circumstances; and be it further

RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity determination must be reviewed by a physician in the same specialty or by another appropriate health care professional for non-physician health care providers.

203. MEDICAID PATIENT ACCOUNTABILITY
Introduced by Florida

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-390.849 AND H-406.991 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association advocate that physicians' Healthcare Effectiveness Data and Information Set and other quality scores and ratings not be affected by non-compliant patients or patients whose parents exercise state exemptions from recommended treatment.

204. STAFFING RATIOS IN THE EMERGENCY DEPARTMENT
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-130.958

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the Emergency Department; and be it further

RESOLVED, that our AMA support that all Emergency Departments be staffed 24-7 by a qualified physician.

205. MEDICAL-LEGAL PARTNERSHIPS & LEGAL AID SERVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-265.986

RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs.

206. INDIAN HEALTH SERVICE YOUTH REGIONAL TREATMENT CENTERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.942

RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as culturally-rooted, behavioral health and substance use disorder treatment centers for American Indian/Alaskan Native (AI/AN) youth.

207. BIOSIMILAR USE RATES AND PREVENTION OF PHARMACY BENEFIT MANAGER ABUSE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
ADDITIONAL PROPOSED RESOLVED REFERRED
See Policy H-125.973

RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake.

[Editor's note: The following proposed 1st and 2nd order amendments, which would be an additional resolve was referred.]
RESOLVED, that our AMA supports coverage structures that increase use of lower cost biosimiliars when clinically appropriate, share savings between payers and patients ~~physicians~~, and reduce patient costs.

208. IMPROVING SUPPLEMENTAL NUTRITION PROGRAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.941

RESOLVED, that our American Medical Association supports extending eligibility for USDA Food Assistance to enrolled members of federally-recognized American Indian and Alaska Native Tribes and Villages to federal feeding programs.

209. NATIVE AMERICAN VOTING RIGHTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-350.940

RESOLVED, that our American Medical Association support Indian Health Service, Tribal, and Urban Indian Health Programs becoming designated voter registration sites to promote nonpartisan civic engagement among the American Indian and Alaska Native population.

210. SUPPORT FOR PHYSICIANS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION
Introduced by Oregon

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 236
See Policy D-385.943

RESOLVED, that our American Medical Association study opportunities for the AMA or physician associations to support physicians initiating and navigating a collective bargaining process, including but not limited to unionization.

211. DECEPTIVE HOSPITAL BADGING 2.0
Introduced by Organized Medical Staff Section

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-35.992, D-405.991, D-405.974, H-35.984, H-360.986, H-405.964 AND H-405.969 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association promote and prioritize public awareness of the difference and importance of having the proper level of training and clear identification and labeling of caregivers as that relates to quality and safety of healthcare; and be it further

RESOLVED, that our AMA work with state and county medical societies to highlight to physicians the growing practice of creating false equivalencies between physicians and non-physicians in the healthcare team and encourage action in local institutions to assure the quality and safety of patient care.

212. ADVOCACY EDUCATION TOWARDS A SUSTAINABLE MEDICAL CARE SYSTEM
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-440.910

RESOLVED, that our American Medical Association explore innovative opportunities for engaging the public in advocacy on behalf of an improved healthcare environment.

213. ACCESS TO COVERED BENEFITS WITH AN OUT OF NETWORK ORDERING PHYSICIAN
Introduced by Private Practice Physicians Section

Resolution 213 was considered with Resolution 245.
See Resolution 245.

RESOLVED, that our American Medical Association develop model legislation to protect patients in direct primary care plans and non-network plans thus furthering the ability of direct primary care physicians and other out-of-network physicians to provide covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, even if it is an HMO or point of service plan; and be it further

RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to support direct primary care and other out-of-network models.

214. SUPPORT FOR PAID SICK LEAVE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-440.823

RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick Leave," as follows:

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave without unduly burdening small businesses.

215. AMERICAN INDIAN AND ALASKA NATIVE LANGUAGE REVITALIZATION AND ELDER CARE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.883

RESOLVED, that our American Medical Association recognize that access to language concordant services for American Indian and Alaska Native (AI/AN) patients will require investment in Indigenous languages in North America; and be it further

RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands; and be it further

RESOLVED, that our AMA support the development of best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service.

216. MERIT-BASED SELECTION OF ADMINISTRATIVE LAW JUDGES
Introduced by American College of Legal Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-265.985

RESOLVED, that our American Medical Association supports merit-based processes for the selection of all Medicare/Medicaid Administrative Law Judges.

217. PROTECTING ACCESS TO IVF TREATMENT
Introduced by American Society for Reproductive Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 226
See Policy D-425.989

RESOLVED, that our American Medical Association oppose any legislation or ballot measures that could criminalize in-vitro fertilization; and be it further

RESOLVED, that our AMA work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that (a) would equate gametes (oocytes and sperm) or embryos with children, and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART); and be it further

RESOLVED, that our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24, on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings, that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART).

218. DESIGNATION OF DESCENDANTS OF ENSLAVED AFRICANS IN AMERICA
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate if from the generic terms African American and Black in glossaries and on medical school applications.

219. BUNDLING FOR MATERNITY CARE SERVICES
Introduced by American College of Obstetricians and Gynecologists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-185.909

RESOLVED, that our American Medical Association supports the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services.

220. RESTORATIVE JUSTICE FOR THE TREATMENT OF SUBSTANCE USE DISORDERS
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-95.899

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports efforts for incarcerated individuals to participate in a treatment or diversion program, and (3) supports providing access to social services and family therapy during and after incarceration; and be it further

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports stigma reduction, implicit bias and antiracism training for medical professionals working in correctional facilities.

221. REFORMING MEDICARE PART B DRUG REIMBURSEMENT TO PROMOTE PATIENT AFFORDABILITY AND PHYSICIAN PRACTICE SUSTAINABILITY
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-330.864

RESOLVED, that our American Medical Association support the creation of a new reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug, and 2) Ensures adequate compensation for the cost of

acquisition, inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price: and be it further

RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients.

222. STUDYING AVENUES FOR PARITY IN MENTAL HEALTH & SUBSTANCE USE COVERAGE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-185.971

RESOLVED, that our American Medical Association increase advocacy efforts towards the National Association of Insurance Commissioners (NAIC) and state and federal policymakers for meaningful financial and other penalties for insurers that do not comply with mental health and substance use parity laws; and be it further

RESOLVED, that our American Medical Association work with state medical societies to advocate to state departments of insurance for meaningful enforcement of penalties for insurers that do not comply with mental health and substance use parity laws.

223. INCREASE IN CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION FUNDING
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-305.949

RESOLVED, that our American Medical Association collaborate with other relevant medical organizations to support and advocate for increased funding for the Children's Hospitals Graduate Medical Education program, recognizing the vital role it plays in shaping the future of pediatric healthcare in the United States.

224. ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **RESOLVES 1 AND 3 ADOPTED AS FOLLOWS**
RESOLVE 2 REFERRED
See Policy H-60.895

RESOLVED, that our American Medical Association supports policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity; and be it further

RESOLVED, that our AMA supports child welfare agency practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity.

[Editor's note: The following resolve was referred]
RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist.

225. HUMANITARIAN EFFORTS TO RESETTLE REFUGEES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States.

226. PROTECTING ACCESS TO IVF TREATMENT
Introduced by Missouri and Endocrine Society

Resolution 226 was considered with Resolution 217.
See Resolution 217 which was adopted in lieu of 226.

RESOLVED, that our American Medical Association oppose any legislation that could criminalize in-vitro fertilization; and be it further

RESOLVED, that our AMA work with other interested organizations to oppose Court rulings that equate gametes (oocytes and sperm) or embryos with children.

227. MEDICARE REIMBURSEMENT FOR TELEMEDICINE
Introduced by Missouri

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-480.932

RESOLVED, that our American Medical Association support removal of the December 31, 2024 "sunset" date currently set for Medicare to cease reimbursement for services provided via telemedicine, such that reimbursement of medical services provided by telemedicine be continued indefinitely into the future, consistent with what would be determined by the Relative Value Update Committee ("RUC").

228. WAIVER OF DUE PROCESS CLAUSES
Introduced by Missouri

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-230.982

RESOLVED, that our American Medical Association advocate that waiver of due process clauses be eliminated from all employment agreements between employed physicians and their non-physician employers, and be declared unenforceable in physicians' previously-executed employment agreements between physicians and their non-physician employers that currently exist; and be it further

RESOLVED, that our AMA will engage in advocacy for adoption of such legislation to eliminate waiver of due process clauses at the federal level.

229. PSILOCYBIN AND PSYCHEDELICS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-120.917

RESOLVED, that our American Medical Association oppose any legislative efforts related to legalization of Psilocybin/Psilocin or its related substances use, except those which have received FDA approval or those prescribed in the context of approved investigational studies; and be it further

RESOLVED, that our AMA support decriminalization of possession of psychedelics, entactogens, or related substances for personal use.

230. PROTECTING PATIENTS FROM INAPPROPRIATE DENTIST AND DENTAL HYGIENIST SCOPE OF PRACTICE EXPANSION
Introduced by American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Contact Dermatitis Society and American College of Mohs Surgery, American Society of Plastic Surgeons, American Academy of Facial Plastics and Reconstructive Surgery, The Aesthetic Society

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-35.974

RESOLVED, that our American Medical Association advocacy efforts recognize the threat posed to patient safety when dentists and dental hygienists are authorized to practice medicine and administer procedures outside their level of education and training; and be it further

RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists and dental hygienists to practice outside their level of education and training.

231. SUPPORTING THE ESTABLISHMENT OF RARE DISEASE ADVISORY COUNCILS
Introduced by American College of Medical Genetics and Genomic

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association will support state legislation for the establishment of Rare Disease Advisory Councils in each state

232. MEDICARE ADVANTAGE PART B DRUG COVERAGE
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-330.894

RESOLVED, that our American Medical Association will advocate with Congress, through the appropriate oversight committees, and with the Centers for Medicare & Medicaid Services (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay.

233. PROHIBITING MANDATORY WHITE BAGGING
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-100.963

RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging policies that condition coverage of a clinician-administered drug, such as an IV infusion, on the drug being dispensed from a pharmacy benefit manager-affiliated mail order pharmacy.

234. STATE PRESCRIPTION DRUG AFFORDABILITY BOARDS - STUDY
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-110.984

RESOLVED, that our American Medical Association conduct a study to determine how upper payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will impact reimbursement for physician-administered drugs and what impact state UPLs will have on patient access to care

235. ESTABLISH A CYBER-SECURITY RELIEF FUND
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-478.957

RESOLVED, that our American Medical Association, through appropriate channels, advocate for a 'Cyber Security Relief Fund" to be established by Congress; and be it further

RESOLVED, that the "Cyber Security Relief Fund" be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer; and be it further

RESOLVED, that the "Cyber Security Relief Fund" only be utilized for 'uninterrupted' payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments.

236. SUPPORT OF PHYSICIANS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION
Introduced by Delaware

Resolution 236 was considered with Resolution 210.
See Resolution 210 which was adopted in lieu of 236.

RESOLVED, that our American Medical Association investigate avenues for the AMA and other physician associations to aid physicians in initiating and navigating collective bargaining efforts, encompassing but not limited to unionization.

237. ENCOURAGING THE PASSAGE OF THE PREVENTIVE HEALTH SAVINGS ACT (S.114)
Introduced by American College of Preventive Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-155.994, H-425.988, H-460.894, AND H-425.987 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association encourages continued advocacy to federal and state legislatures of the importance of more accurately and effectively measuring the health and economic impacts of investing in preventive health services to improve health and reduce healthcare spending costs in the long term. (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm the following policy: D-155.994, "Value-Based Decision Making in the Health Care System" to encourage legislation and efforts to allow the Congressional Budget Office to more effectively project long-term budget deficit reductions and costs associated with legislation related to preventive health services.

238. AMA SUPPORTS EFFORTS TO FUND OVERDOSE PREVENTION SITES
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-95.898

RESOLVED, that our American Medical Association support legislation or regulation that would fund overdose prevention sites.

239. REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY THE NATIONAL TOLLFREE QUIT NOW HOTLINE
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-505.997

RESOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the national tobacco cessation quitline portals and telephone hotlines, in multiple languages and/or the corresponding information for a given state or territory.

240. EXPANDING VISA REQUIREMENT WAIVERS FOR NY IMGS WORKING IN UNDERSERVED AREAS
Introduced by New York

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-200.982
REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association supports reauthorization and expansion of the Conrad-30 J-1 visa waiver program, including permitting reallocation of unused slots to states that have already used the maximum number of waivers.

241. HEALTHCARE CYBERSECURITY BREACHES
Introduced by New York

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-478.960
REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association advocate for the development of an adequately funded multidisciplinary task-force including representation of AMA, health insurers, the FBI and other pertinent stakeholders to prevent future healthcare cyberattacks throughout the country and to increase the apprehension of cybercriminals who prey on patients and healthcare entities, and to recommend appropriate penalties for their crimes.

242. HEALTH CARE ACCESS FOR AMERICAN INDIANS AND ALASKA NATIVES
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-350.939

RESOLVED, that our American Medical support the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system; and be it further

RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care.

RESOLVED, That our AMA support federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices.

243. DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF FEDERALLY RECOGNIZED TRIBES
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association add "Enrolled Member of a Federally Recognized Tribe" on all AMA demographic forms; and be it further

RESOLVED, that our AMA advocate for the use of "Enrolled Member of a Federally Recognized Tribe" as an additional category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and be it further

RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of "Enrolled Member of a Federally Recognized Tribe" on all AAMC demographic forms; and be it further

RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include "Enrolled Member of a Federally Recognized Tribe" on all ACGME demographic forms.

244. GRADUATE MEDICAL EDUCATION OPPORTUNITIES FOR AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES H-350.977, H-350.976, AND D-305.967 REAFFIRMED IN LIEU OF THE FOLLOW RESOLUTION

RESOLVED, that our American Medical Association supports policy and communication efforts to (1) advance legislative and regulatory policies and actions that establish, authorize, fund, and incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities and (2) establish associated partnerships with accredited medical schools and teaching hospitals; and be it further

RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal organizations, academic medical centers, policy professionals, medical schools, teaching hospitals, coalition builders, and other stakeholders to advocate to Congress, The White House, the Department of Health and Human Services, and other government entities to establish dedicated graduate medical education funding and programs that benefit Tribal communities, increase physician training sites, and reduce physician shortages, particularly among underserved populations.

245. PATIENT ACCESS TO COVERED BENEFITS ORDERED BY OUT-OF-NETWORK PHYSICIANS
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RESOLUTION 245 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 213
See Policies D-285.958

RESOLVED, that our American Medical Association develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial

insurance, based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability; and be it further

RESOLVED, that our AMA collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models.

246. AUGMENTED INTELLIGENCE IN HEALTH CARE
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED FOR REPORT BACK AT I-24

[Editor's Note: Resolution 246 was considered with BOT 15 and Resolution 202 which were also referred for report at I-24.]

RESOLVED, that our American Medical Association amend its augmented intelligence policy to align with the following:

Augmented Intelligence in Health Care

The American Medical Association supports the use of augmented intelligence (AI) when used appropriately to support physician decision-making, enhance patient care, improve administrative functions, and improve public health without reducing the importance of physician decision-making. Augmented intelligence also should be used in ways that reduce physician burden and increase professional satisfaction. Sufficient safeguards should be in place to assign appropriate liability inherent in augmented intelligence to the software developers and not to those with no control over the software content and integrity, such as physicians and other users. Ultimately, it is the physician's responsibility to uphold the standard of care.

The American Medical Association adopts the following principles for augmented intelligence in health care:

1. Augmented intelligence should be the preferred health care term over artificial intelligence as it should be used to augment care by providing information for consideration. Augmented intelligence, whether assistive or fully autonomous, is intended to co-exist with human decision-making and should not be used to replace physician reasoning and knowledge.
2. Physicians should not be mandated to use augmented intelligence without having input or feedback into how the tool is used either individually or as a medical staff.
3. Augmented intelligence must not replace or diminish the patient-physician relationship.
4. Algorithms developed to augment user intelligence must be designed for the benefit, safety, and privacy of the patient. The AMA should research opportunities to place practicing physicians on public and private panels, work groups, and committees that will evaluate products as they are developed.
5. Sellers and distributors of augmented intelligence should disclose that it has met all state and federal legal and regulatory compliance with regulations such as, but not limited to, those of HIPAA, the U.S. Department of Health and Human Services, and the U.S. Food and Drug Administration.
6. Use of augmented intelligence, machine learning, and clinical decision support has inherent known risks. These risks should be recognized, and legal and ethical responsibility for the use and output of these products must be assumed by, including but not limited to, developers, distributors, and users with each entity owning responsibility for its respective role in the development, dissemination, implementation, and use of products used in clinical care.
7. Users should have clear guidelines for how and where to report any identified anomalies. Additionally, as with all technology, there should be a national database for reporting errors that holds developers accountable for correcting identified issues.
8. Before using augmented intelligence, physicians and all users should receive adequate training and have educational materials available for reference, especially in instances where the technology is not intuitive and there are periods of nonuse.
9. Physicians should inquire about whether the AI used is a "continuously learning system" versus a "locked system." A locked system is more appropriate for clinical care, although a hybrid system may be appropriate

as long as the clinical output is based on locked training sets. A locked system gives a predictable output, whereas a continuous learning system will change over time.

10. Algorithms and other information used to derive the information presented as augmented intelligence to physicians and other clinicians should:
    a. Be developed transparently in a way that is accessible, explainable, and understandable to clinicians and patients and details the benefits and limitations of the clinical decision support, and/or augmented intelligence
    b. Have reproducible and explainable outputs
    c. Function in a way that promotes health equities while eliminating potential biases that exacerbate health disparities
    d. Use best practices for user-centered design that allows for efficient and satisfactory use of the technology;
    e. Safeguard patient information by employing privacy and security standards that comply with HIPAA and state privacy regulations
    f. Have a feedback loop that allows users who identify potential safety hazards to easily report problems and malfunctions as well as opportunities to report methods for improvements; and
    g. Contain a level of compatibility to allow use of information between hardware and software made by different manufacturers.
11. Medical students and residents need to learn about the opportunities and limitations of augmented intelligence as they are prepared for future medical practice.
12. The AMA will advocate, through legislation or regulation, for payment to physicians for utilization of artificial intelligence tools that have additional cost or require additional time.
13. Recognizing the rapid pace of change in augmented intelligence, it is important to continually assess and update the AMA's principles at regular intervals.

247. PROHIBIT HEALTH BENEFIT PLANS FROM CHARGING COST SHARING FOR COVERED PROSTATE CANCER SCREENING
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-110.961

RESOLVED, that our American Medical Association support federal legislation requiring that health benefit plans may not charge any form of cost sharing for covered prostate cancer screening.

248. SUSTAIN FUNDING FOR HRSA (HEALTH RESOURCES SERVICES AND ADMINISTRATION) 340B GRANT-FUNDED PROGRAMS
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association amend Policy H-110.985 340B Drug Discount Program by addition as follows:

> Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; (2) will support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; (3) recognizes the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients; (4) will support a revised 340B drug discount program covered entity

eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices; ~~and~~ (5) will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program~~.~~; and (6) supports 340B programs funded by HRSA grants in their utilization of the program as legislatively intended.

249. PEDIATRIC SPECIALTY MEDICAID REIMBURSEMENT
Introduced by American College of Rheumatology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-290.972

RESOLVED, that our American Medical Association make increasing Medicaid reimbursement for pediatric specialists a significant part of its plan for continued progress toward health equity; and be it further

RESOLVED, That our AMA advocate for payment parity with Medicare for the same or similar services provided to pediatric patients under Medicaid; and be it further

RESOLVED, that our AMA work with specialty societies to develop a value-based payment model that makes pediatric specialist practices sustainable and promotes access to care and health equity among the pediatric patients; and be it further

RESOLVED, that our AMA work with interested state parties to support the implementation of the value-based payment model for pediatric specialists in state Medicaid programs; and be it further

RESOLVED, That our AMA advocate for any demonstration projects undertaken to modernize Medicaid payment using value based payment models developed by the AMA and pediatric specialty societies be exempt from Medicaid demonstration project budget neutrality requirements.

250. ENDORSEMENT OF THE UNIFORM HEALTH-CARE DECISIONS ACT
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association amend policy D-140.968, “Standardized Advance Directives,” to read as follows:

Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 2023, and work with our state medical societies to advocate for its adoption in the states.

251. STREAMLINE PAYER QUALITY METRICS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTION 251
See Policy D-385.942

RESOLVED, that our American Medical Association will continue to advocate for improvements in private payers' quality programs.

252. MODEL LEGISLATION TO PROTECT THE FUTURE OF MEDICINE
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-295.301

RESOLVED, that our American Medical Association create model state legislation to protect the ability of medical schools and residency/fellowship training programs to have diversity, equity, and inclusion (DEI) and related initiatives for their students, employees, and faculty to ensure the education and implementation of optimized healthcare.

253. ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
TITLE CHANGED
See Policy D-285.957

RESOLVED, that our American Medical Association advocate for the federal departments to immediately and correctly implement the fair and timely Independent Dispute Resolution (IDR) process as stipulated by the No Suprises Act including advocating specifically for the following:

1. Specific requirements for insurers: Insurers must be required to make IDR loss payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and be prohibited from falsely claiming ineligibility due to network status or incorrect venue claims;
2. Operational improvements in the IDR process: IDR entities must not close claims based on unverified insurer claims, an adequate number of IDR entities must be certified, and a structured timeline must be set for IDR entity selection and payment process

REFERENCE COMMITTEE C

301. FAIRNESS FOR INTERNATIONAL MEDICAL STUDENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; and be it further

RESOLVED, that our AMA amend policy H-255.968 "Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools" by addition and deletion to read as follows; and be it further

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968

Our AMA:
1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); ~~and~~
4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and
5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school.

RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.

302. THE ROLE OF MAINTENANCE OF CERTIFICATION
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: POLICIES D-275.954, H-275.924, AND H-275.926 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association adopt a policy that states that maintenance of certification requirements should not be duplicative of continuing medical education requirements and not be used to determine or dictate hospital privileges, insurance network credentialing, or hiring practices.

RESOLVED, that our AMA recognizes the importance of fostering competition in the market for board certification, allowing physicians to have the autonomy to choose the most suitable pathway for their individual learning and professional development needs.

RESOLVED, that our AMA undertake a comprehensive review of the available evidence concerning the impact of maintenance of certification on the quality and safety of patient care and report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy with a report back to the House of Delegates by Annual 2025.

303. AMEND POLICY D-275.948 TITLE "EDUCATION, TRAINING AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING". CREATION OF AN AMA TASK FORCE TO ADDRESS CONFLICTS OF INTEREST ON PHYSICIAN BOARDS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association amend the title of policy D-275.948 by substitution and deletion as follows:

~~Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training~~ Addressing Non-physician Positions and Participation on Physician Regulatory Boards and Bodies and Potential Conflicts of Interest D-275.948

RESOLVED, that our AMA work with relevant stakeholders and regulatory bodies and boards involved in physician education, accreditation, certification, licensing, and credentialing to advocate for physician leadership of these regulatory bodies and boards in order to be consistent with the AMA Recovery Plan's efforts to fight scope creep, and prevent undermining physician confidence in these organizations

RESOLVED, that our AMA create a task force with the mission to increase physician awareness of and participation in leadership positions on regulatory bodies and boards involved in physician education, accreditation, certification, licensing, and credentialing through mechanisms including but not limited to mentorship programs, leadership training programs, board nominations, publicizing the opportunities to the membership, and creating a centralized list of required qualifications and methods to apply for these positions.

304. SPIRITUALITY IN MEDICAL EDUCATION AND PRACTICE
Introduced by Academic Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.900

RESOLVED, that our American Medical Association amend Policy H-160.900 to read as follows:

~~Addressing~~ Patient Spirituality in ~~Medicine~~ Medical Education and Practice

(1) Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services.

(2) That our AMA supports promotion of medical education curricula on spiritual health.

305. PUBLIC SERVICE LOAN FORGIVENESS REFORM
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.977

RESOLVED, that our American Medical Association amend Indian Health Service H-350.977 by addition and deletion as follows:

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends:

(1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Personnel ~~Manpower~~: (a) Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for specialty and primary care service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing ~~manpower~~ and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
(8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
(9) Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

306. UNMATCHED GRADUATING PHYSICIANS
Introduced by Edmond Cabbabe, MD, Delegate

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the House of Delegates at the next Interim meeting.

307. ACCESS TO REPRODUCTIVE HEALTH SERVICES WHEN COMPLETING PHYSICIAN CERTIFICATION EXAMS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: FOLLOWING ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 307
See Policy D-275.944

RESOLVED that our American Medical Association encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners.

RESOLVED that our American Medical Association study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.

308. TRANSFORMING THE USMLE STEP 3 EXAMINATION TO ALLEVIATE HOUSESTAFF FINANCIAL BURDEN, FACILITATE HIGH-QUALITY PATIENT CARE, AND PROMOTE HOUSESTAFF WELL-BEING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-275.914

RESOLVED, that our American Medical Association supports changing the United States Medical Licensing Examination (USMLE) Step 3 and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 3 from a numerically-scored examination to a pass/fail examination; and be it further

RESOLVED, that our AMA supports changing USMLE Step 3 and COMLEX-USA Level 3 from a two-day examination to a one-day examination

RESOLVED, that our AMA supports the option to take USMLE Step 3 after passing Step 2-Clinical Knowledge (CK) or take COMLEX-USA Level 3 after passing Level 2-Cognitive Evaluation (CE) during medical school

RESOLVED, that our AMA advocates that residents taking the USMLE Step 3 or COMLEX-USA Level 3 exam be allowed days off to take the exam without having this time counted for paid time off (PTO) or vacation balance.

309. DISAFFILIATION FROM THE ALPHA OMEGA ALPHA HONOR MEDICAL SOCIETY DUE TO PERPETUATION OF RACIAL INEQUITIES IN MEDICINE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association recognizes that the Alpha Omega Alpha Honor Medical Society disproportionately benefits privileged trainees

RESOLVED, that our AMA supports institutional disaffiliation from the Alpha Omega Alpha Honor Medical Society due to its perpetuation of racial inequities in medicine

RESOLVED, that our AMA recognizes that the Alpha Omega Alpha Honor Medical Society perpetuates and accentuates discrimination against trainees of color that is inherent in medical training.

310. ACCOUNTABILITY & TRANSPARENCY IN GME FUNDING WITH ANNUAL REPORT
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-305.929 and D-305.967

RESOLVED, that our American Medical Association ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year; and be it further

RESOLVED, that our AMA reaffirm policy H 305.929.

311. PHYSICIAN PARTICIPATION IN HEALTHCARE ORGANIZATIONS
Introduced by Pennsylvania

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-405.953 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association reaffirm H 405.953.

312. AMA COLLABORATION WITH FSMB TO ASSIST IN LICENSING REENTRANT PHYSICIANS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-300.984

RESOLVED, that our American Medical Association work with the FSMB, specialty and subspecialty societies, and other relevant stakeholders to study and develop evidence-based criteria for determining a physician's readiness to reenter practice and identify resources for the evaluation and retraining of physicians seeking to reenter active practice.

RESOLVED, that our AMA supports legislative and other efforts to help offset the direct costs to physicians of participating in re-entry processes.

313. CONTINUING MEDICAL EDUCATION RESOURCES FOR PRECEPTORSHIP
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-300.972

RESOLVED, that our American Medical Association along with the Council of Medical Education, formulate a "toolkit" to teach physicians who serve as preceptors, especially in rural and underserved areas, how to be better preceptors and the process on claiming AMA Category 1 credits for preparation and teaching medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and /Accreditation Council for Graduate Medical Education accredited institutions, thereby making them a more effective preceptor.

314. PROMOTE AWARENESS OF FEDERAL GAINFUL EMPLOYMENT REGULATIONS AND TRANSPARENCY PROVISIONS
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: FIRST RESOLVE ADOPTED AS FOLLOWS
POLICY H-305.925 REAFFIRMED IN LIEU OF SECOND RESOLVE
TITLE CHANGED
See Policies D-305.948 and H-305.925

RESOLVED, that our American Medical Association promote awareness of the work of our AMA and American Association of Medical Colleges related to federal gainful employment regulations and transparency provisions.

[Editor's Note: Policy H-305.925 reaffirmed in lieu of following second resolve]
RESOLVED, that our AMA continue to work with key stakeholders and advocate for the resolution of the student loan crisis to protect physicians from unaffordable student debt and poor earning outcomes.

315. CEASE REPORTING OF TOTAL ATTEMPTS OF USMLE STEP1 AND COMLEX-USA LEVEL 1 EXAMINATIONS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate that NBME and NBOME cease reporting the total number of attempts of the STEP1 and COMLEX-USA Level 1 examinations to residency and fellowship programs and licensure.

316. REASSESSMENT OF CONTINUING BOARD CERTIFICATION PROCESS
Introduced by New England

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: POLICIES D-275.954 AND H-275.924 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association undertake a thorough review and analysis of the available literature, data, and evidence to re-examine and update the accepted standards for continuing board certification including policy H-275.926, Medical Specialty Board Certification Standards, so the standards reflect the best manner to assess physicians' knowledge and skills necessary to practice medicine.

317. PHYSICIAN PARTICIPATION IN THE PLANNING AND DEVELOPMENT OF ACCREDITED CONTINUING EDUCATION FOR PHYSICIANS
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association petition the Accredited Continuing Medical Education to develop policies which require physician participation in the planning and development of accredited continuing education for physicians.

318. VARIATION IN BOARD CERTIFICATION AND LICENSURE REQUIREMENTS FOR INTERNATIONALLY-TRAINED PHYSICIANS AND ACCESS TO CARE
Introduced by American Urological Association

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association work with the American Board of Medical Specialties to study the variation in board certification requirements for internationally trained physicians as well as the impact this may have on physician practices and addressing physician shortages including the impact of these pathways on maintaining public assurance of a well-trained physician workforce

RESOLVED, that our AMA study the potential effects of increasing access to board certification for internationally-trained physicians on projected physician workforce shortages

RESOLVED, that our AMA work with the Federation of State Medical Boards to study the existing alternate pathways to licensure for physicians who have not completed an ACGME-accredited post-graduate training program and the positive and negative impacts of these pathways on addressing physician shortages.

319. AMA SUPPORT OF U.S. PATHWAY PROGRAMS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 319
See Policy D-200.970

RESOLVED, that our American Medical Association supports development of pilot grant programs advised by a diverse body of AMA member physicians, trainees, staff, and allied organization representatives in medicine and public health (i.e., administration; grantee criteria and selection; periodic reporting) that will a) support existing and new pre-K-16 pathway, Science, Technology, Engineering, Math, and Medicine (STEMM), and pre-med programs; b) include program goals of scaling organizational grantees' ability to expand their reach among youth, increasing diversity in medicine, achieving health equity, and improving medical education; and c) convene a summit among pathway and STEMM programs regarding best practices, collaboration, and strategic planning.

320. ANTI-RACISM TRAINING FOR MEDICAL STUDENTS AND MEDICAL RESIDENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: POLICY H-65.952 REAFFIRMED IN LIEU OF RESOLUTION 320

RESOLVED, that our American Medical Association advocate that the Liaison Committee on Medical Education and Association of American Medical Colleges require, rather than encourage, anti-racism training for medical students and medical residents.

REFERENCE COMMITTEE D

401. ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH CLOSED LOOP REFERRAL SYSTEMS
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy D-165.932

RESOLVED, that our American Medical Association study the effectiveness and best practices of closed loop referral systems in addressing social determinants of health

402. GUARDIANSHIP AND CONSERVATORSHIP REFORM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy); and be it further

RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life.

403. OCCUPATIONAL SCREENINGS FOR LUNG DISEASE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-365.988

RESOLVED, that our AMA amend Policy H-365.988, "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by addition and deletion as follows:

> Our AMA ~~supports~~: (1) supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) supports taking a leadership role in assisting state medical societies in implementation of such programs; and (3) supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognizes barriers to accessibility and utilization of such programs; (5) recognizes inequities in occupational health screenings for pulmonary disease and supports efforts to increase accessibility of these screenings; and (6) encourages utilization of free and accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at-risk occupational groups.

404. PROTECTIONS AGAINST SURGICAL SMOKE EXPOSURE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support efforts to limit surgical smoke exposure in operating rooms.

405. DEFAULT PROCEED FIREARM SALES AND SAFE STORAGE LAWS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policies H-145.990 and H-145.996

RESOLVED, that our American Medical Association amend Policy H-145.996, "Firearm Availability," by addition as follows; and be it further

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; (c) opposes firearm sales to individuals for whom a background check has not been completed; (d) opposes destruction of any incomplete background checks for firearm sales; (e) advocates for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state lines, or via other means; and average time passed between background check completion and retrieval; and (fe) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
4. Our AMA advocates for (a) federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without
adhering to all federal and state requirements for background checks, waiting periods, and licensure; (b) federal and state policies to prevent "multiple sales" of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and (c) federal and state policies implementing background checks for ammunition purchases.

RESOLVED, that our American Medical Association amend Policy H-145.990, "Prevention of Firearm Accidents in Children," by addition as follows:

Prevention of Firearm Accidents in Children H-145.990
1) Our AMA (a) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (i) inquire as to the presence of household firearms as a part of childproofing the home; (ii) educate patients to the dangers of firearms to children; (iii) encourage patients to educate their children and neighbors as to the dangers of firearms; and (iv) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from

firearms;(b) encourages state medical societies to work with other organizations to increase public education about firearm safety; (c) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (d) supports enactment of Child Access Prevention laws and other types of comprehensive safe storage laws that are consistent with AMA policy.
2) Our AMA and all interested medical societies will (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

406. OPPOSITION TO JUSTICE INVOLVED FEES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-430.991

RESOLVED, that our American Medical Association oppose fees charged to justice involved individuals for room and board and advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board and basic amenities; and be it further

RESOLVED, that our AMA oppose probation and parole supervision fees and support federal and state efforts to repeal statutes and ordinances which permit individuals on probation or parole to be charged for supervision fees.

407. RACIAL MISCLASSIFICATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-85.953

RESOLVED, that our American Medical Association amend H-85.953, "Improving Death Certification Accuracy and Completion," by addition as follows:

Improving Death Certification Accuracy and Completion H-85.953
1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.
2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.
3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions,

categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.

4. Our AMA further supports HIPAA-compliant, Tribally approved data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification.

408. INDIAN WATER RIGHTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy D-135.963

RESOLVED, that our American Medical Association raise awareness about ongoing water rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in appropriate forums; and be it further

RESOLVED, that our AMA support improving access to water and adequate sanitation, water treatment, and environmental support and health services on American Indian and Alaska Native trust lands.

409. HAZARDOUS POLLUTANTS AND HEAVY METALS
Introduced by Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-135.962

RESOLVED, that our American Medical Association urge governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air; and be it further

RESOLVED, that our AMA support efforts: (a) to monitor the chronic effects of exposure to hazardous pollutants and heavy metals including at levels below regulation limits, (b) to monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites, and (c) to educate individuals on the chronic effects of those exposures.

410. EQUITY IN ACCESS TO PUBLIC RESTROOMS
Introduced by Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-65.940

RESOLVED, that our American Medical Association support access to clean, accessible, and permanent public restrooms that, at minimum, contain a toilet and sink, regardless of any identifying characteristics such as gender identity, appearance, employment status, or commercial status; and be it further

RESOLVED, that our AMA support equity in restroom access by gender identity, including increasing the number of female and gender-neutral bathrooms available in both new and existing buildings.

411. MISSING AND MURDERED INDIGENOUS PERSONS
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.938

RESOLVED, that our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on tribal reservations and elsewhere.

412. LITHIUM BATTERY SAFETY
Introduced by Indiana

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-135.906

RESOLVED, that our American Medical Association support legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries.

RESOLVED, that the AMA support educational efforts to inform the public about the proper disposal and recycling of lithium batteries and the risks of improper storage and disposal of lithium batteries.

413. SEXUALITY AND REPRODUCTIVE HEALTH EDUCATION
Introduced by Michigan

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-170.968 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association reaffirm AMA Policy H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools," and continue to advocate for the adoption of developmentally appropriate, culturally sensitive, comprehensive sexuality and reproductive health education and reproductive rights curriculum.

414. ADDRESSING THE HEALTH SECTOR'S CONTRIBUTIONS TO THE CLIMATE CRISIS
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.973

RESOLVED, that our American Medical Association recognizes that clinical quality and safety should not be sacrificed as strategies for reducing greenhouse gasses and waste; and be it further

RESOLVED, that our AMA recognizes that animal-based agriculture is a significant contributor to greenhouse gas emissions and supports efforts to increase and promote plant-based menu options in hospital food services, for both health and environmental reasons; and be it further

RESOLVED, that our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions; and be it further

RESOLVED, that our AMA opposes corporate "greenwashing," or the act of making misleading statements about the environmental benefits of products and/or services; and be it further

RESOLVED, that our AMA supports the development of locally managed and reliable electrical microgrids that operate independently from the larger electrical grid for hospitals and other health care facilities to use as a way to reduce reliance on diesel generation for back-up services while maintaining critical care functions during emergencies and supports grants being provided to independent practices to facilitate this development; and be it further

RESOLVED, that our AMA support the use of virtual health care, where appropriate, with reasonable reimbursement, as a strategy to reduce the carbon footprint of health care; and be it further

RESOLVED, that our AMA support financial assistance for health care entities, including community health centers, clinics, rural health centers, small- and medium-sized physician practices, transitioning to environmentally sustainable operations; and be it further

RESOLVED, that our AMA support the development of concise clinical guidelines and patient education materials to assist physician practices and patients to reduce adverse organizational and personal impacts on climate change.

415. BUILDING ENVIRONMENTAL RESILIENCY IN HEALTH SYSTEMS AND PHYSICIAN PRACTICES
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy H-135.923

RESOLVED, that our American Medical Association support a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change; and be it further

RESOLVED, that our AMA encourage health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities; and be it further

RESOLVED, that our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity.

416. FURTHERING ENVIRONMENTAL JUSTICE AND EQUITY
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-135.905

RESOLVED, that our American Medical Association support state and local climate-health risk assessments, disease surveillance and early warning systems, and research on climate and health, with actions to improve and/or correct the findings; and be it further

RESOLVED, that our AMA support measures to protect frontline communities from the health harms of proximity to fossil fuel extraction, refining and combustion, such as the best available technology to reduce local pollution exposure from oil refineries, or health safety buffers from oil extraction operations; and be it further

RESOLVED, that our AMA support prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practice with full participation by the community residents in these decisions.

417. ADDRESSING THE HEALTH RISKS OF EXTREME TEMPERATURES

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 417 AND 419
See Policy H-135.904

RESOLVED, that our American Medical Association support the creation of federal occupational outdoor heat standards and the establishment of enforceable indoor temperature standards (addressing both cold and hot temperatures), for occupational settings, incarceration facilities (e.g., prisons, jails, and detention centers), schools, licensed health care and other congregate facilities; and be it further

RESOLVED, that our American Medical Association support funding for cooling and heating centers as well as subsidizing energy costs to provide adequate heating and cooling for low-income households to maintain safe temperatures during periods of extreme temperature.

418. EARLY AND PERIODIC EYE EXAMS FOR ADULTS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-25.990

RESOLVED, that our American Medical Association (AMA) amend policy H-25.990 "Eye Exams for the Elderly" by addition to read as follows**:**

Eye Exams for the Elderly and Adults H-25.990
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients and adults who suffer from chronic systemic conditions that increase their likelihood of developing eye disease as well as a baseline eye examination for all adults aged 40 and above. (2) Our AMA encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

419. ADDRESSING THE HEALTH RISKS OF EXTREME HEAT
Introduced by Medical Student Section

Resolution 419 was considered with Resolution 417.
See Resolution 417.

RESOLVED, that our American Medical Association support funding for subsidizing energy costs and air conditioning units for low-income households to maintain safe temperatures during periods of extreme temperature; and be it further

RESOLVED, that our AMA support the implementation and enforcement of state and federal temperature standards in prisons, jails, and detention centers, including the implementation of air conditioning in areas that experience dangerously high temperatures.

420. EQUITY IN DIALYSIS CARE
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-350.974

RESOLVED, that our American Medical Association declare kidney failure as a significant public health problem with disproportionate affects and harm to under-represented communities; and be it further

RESOLVED, that our AMA vigorously pursue potential solutions and partnerships to identify economic, cultural, clinical and technological solutions that increase equitable access to all modalities of care including home dialysis.

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

RESOLVED, that our AMA support a nationwide American Indian and Alaskan Native Medicare and Medicaid enrollment campaign coordinated by CMS and the IHS that funds insurance navigator programs at Tribal Health Programs to improve equitable access to dialysis care.

421. ANNUAL CONFERENCE ON THE STATE OF OBESITY AND ITS IMPACT ON DISEASE IN AMERICA (SODA)
Introduced by American Society for Metabolic and Bariatric Surgery

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association convene an annual meeting of its Federation partners to comprehensively review the impact of obesity on hypertension, cardiovascular disease, type 2 diabetes, metabolic dysfunction-associated hepatitis (MASH) and other related comorbidities with a focus on monitoring epidemiology, developing algorithms to combat disease progression, and coordinating efforts to improve access to care; and be it further

RESOLVED, that our AMA shall feature presentations, workshops, and panel discussions covering the latest research findings, clinical guidelines, and best practices related to the prevention, diagnosis, and management of obesity-related chronic diseases; and be it further

RESOLVED, that our AMA shall invite renowned experts, researchers, clinicians, policymakers, and patient advocates to contribute their insights, experiences, and recommendations during the annual meeting; and be it further

RESOLVED, that our AMA that shall collaborate with relevant stakeholders, including government agencies, healthcare systems, insurers, community organizations, and industry partners, to develop and implement strategies for combating obesity-related chronic diseases; and be it further

RESOLVED, that our AMA assist in the discussion of epidemiological trends, development of evidence-based algorithms for disease management, and coordination of efforts to improve access to care for patients affected by obesity-related chronic diseases; and be it further

RESOLVED, that our AMA shall publish a comprehensive report summarizing the discussions, findings, and recommendations from each annual meeting and disseminate it to member organizations, policymakers, healthcare providers, and the public; and be it further

RESOLVED, that the AMA shall convene the first annual meeting in 2025 and subsequent meetings annually thereafter.

422. IMMUNIZATION REGISTRY
Introduced by Ohio

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-440.899

RESOLVED, that our AMA support mandating all vaccine providers to report all immunizations to their respective state immunization registry, for both adults and children

423. HPV VACCINATION TO PROTECT HEALTHCARE WORKERS OVER AGE 45

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ALTERNATE RESOLUTION 423 ADOPTED**
IN LIEU OF RESOLUTION 423
See Policy D-405.967

RESOLVED, that our AMA encourage the CDC to review the available evidence for recommending the HPV vaccine for health care professionals to prevent health care related infection of HPV (Directive to Take Action); and be it further

RESOLVED, that our AMA supports the need for additional ongoing research regarding minimization of occupational exposure to HPV, including through use of personal protective equipment.

424. LGBTQ+ OLDER ADULTS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-65.979

RESOLVED, that our American Medical Association create and disseminate educational content to increase awareness and understanding of LGBTQ+ health aging issues among the general public, healthcare professionals, and policy makers; and be it further

RESOLVED, that our AMA promote cultural competency training for clinicians in caring for LGBTQ+ older adults; and be it further

RESOLVED, that our AMA promote policies and practices for implementation within all healthcare settings that are inclusive and affirming for LGBTQ+ older adults; and be it further

RESOLVED, that our AMA advocate for increased funding and resources for research into health issues of LGBTQ+ older adults.

425. PERINATAL MENTAL HEALTH DISORDERS AMONG MEDICAL STUDENTS AND PHYSICIANS
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy

RESOLVED, that our American Medical Association work with relevant stakeholders to identify ways to increase screening and referrals to services for perinatal mental health conditions, including substance use disorder, with privacy protections, among medical students, physicians, and their families and reduce stigma surrounding the diagnosis and treatment of perinatal mental health conditions, including substance use disorder, with privacy protections; and be it further

RESOLVED, that our AMA advocate for reducing structural and systemic barriers to the diagnosis and treatment of perinatal mental health conditions, including substance use disorder, with privacy protections, in physicians, medical students and their families.

426. MATERNAL MORBIDITY AND MORTALITY: THE URGENT NEED TO HELP RAISE PROFESSIONAL AND PUBLIC AWARENESS AND OPTIMIZE MATERNAL HEALTH – A CALL TO ACTION
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our AMA policy no. D-245.994 be amended to include the importance of all women achieving their healthiest weight before pregnancy, maintaining healthy gestational weight gain and optimizing weight loss postpartum; and be it further

RESOLVED, that our AMA:

a) Advocate for access to effective obesity treatment (either medical or surgical) for patients.
b) Advocate for supporting physicians' ability to provide obstetrical and obesity care.
c) Advocate for additional funding for research on medical technology that influences human behavior to promote healthy living.
d) Reaffirm policy no. H-440.902 and report back at A-25 on research on the medical, psychological, and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity, emphasizing pre-conception, gestational and postpartum obesity.
e) Provide medical recommendations on ways to eliminate barriers identified in prior obesity research by our AMA.
f) Recommend that approaches to obesity prevention and treatment be included as an element of medical education.

427. CONDEMNING THE UNIVERSAL SHACKLING OF EVERY INCARCERATED PATIENT IN HOSPITALS
Introduced by New England

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association condemns the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals and outpatient health care settings; and be it further

RESOLVED, that our AMA advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate; and be it further

RESOLVED, that our AMA advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians.

428. ADVOCATING FOR EDUCATION AND ACTION REGARDING THE HEALTH HAZARDS OF PFAS CHEMICALS
Introduced by New England and Endocrine Society

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-135.916

RESOLVED, that our American Medical Association amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts.

429. ASSESSING AND PROTECTING LOCAL COMMUNITIES FROM THE HEALTH RISKS OF DECOMMISSIONING NUCLEAR POWER PLANTS
Introduced by New England

HOD ACTION: ADOPTED
See Policy D-135.961

RESOLVED, that our American Medical Association advocate for strict limitations of aerosol, soil, and/or water radionuclide releases in the decommissioning of US nuclear power plants in order to protect health, particularly that of local vulnerable populations.

430. CANCER RISKS ASSSOCIATED WITH NOVEL NICOTINE DELIVERY DEVICES
Introduced by New England, The American Society for Radiation Oncology, Association for Clinical Oncology, The American College of Surgeons

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **RESOLVE 1 REFERRED FOR DECISION**
RESOLVE 2 ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-495.991

[Editor's Note: Resolve 1 Referred for Decision]
RESOLVED, that our American Medical Association advocate for information about lung cancer screening to be included within all combustible tobacco product packaging; and be it further

[Editor's Note: Resolve 2 adopted as follows]
RESOLVED, that our AMA will work with appropriate public health organizations and governmental agencies to monitor the impact of novel nicotine delivery devices on cancer epidemiology and promote appropriate cancer screening should the suspected link be proven.

431. COMBATTING THE PUBLIC HEALTH CRISIS OF GUN VIOLENCE
Introduced by Massachusetts

Considered on reaffirmation calendar.

HOD ACTION: **POLICY D-145.992, D-145.995, H-145.975 AND H-145.997 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION**

RESOLVED, that our American Medical Association advocate for and strongly support legislation, regulation, and reform that seeks to address the public health crisis posed by gun violence.

432. DECREASING LEAD EXPOSURE
Introduced by American College of Preventive Medicine

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policies H-60.924 and H-135.928

RESOLVED, that our American Medical Association reaffirm the following policy H-135.928, "Safe Drinking Water" in support of EPA's Lead and Copper Rule and evidence-based research demonstrating there is no safe level of lead for humans and therefore warrants immediate Federal, State, and municipal action; and be it further

RESOLVED, that our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water; and be it further

RESOLVED, that our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies; and be it further

RESOLVED, that our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks; and be it further

RESOLVED, that our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure; and be it further

RESOLVED, that our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas; and be it further

RESOLVED, that our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies

433. IMPROVING HEALTHCARE OF MINORITY COMMUNITIES IN RURAL AREAS
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-350.937

RESOLVED, that our American Medical Association encourage health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas; and be it further

RESOLVED, that our AMA encourage enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life; and be it further

RESOLVED, that our AMA encourage the collection of vital statistics and other relevant demographic data of minority communities in rural areas; and be it further

RESOLVED, that our AMA advise organizations of the importance of minority health in rural areas; and be it further

RESOLVED, that our AMA research and study health issues unique to minority communities in rural areas, such as access to care difficulties; and be it further

RESOLVED, that our AMA channel existing policy for telehealth to support minority communities in rural areas; and be it further

RESOLVED, that our AMA will encourage our Center for Health Equity to support minority health in rural areas through programming, equity initiatives, and other representation efforts.

434. UNIVERSAL NEWBORN EYE SCREENING
Introduced by Michigan

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association amend AMA policy, Standardization of Newborn Screening Programs H-245.973 by addition and deletion as follows:

> Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; and (3) supports screening for critical congenital heart defects for newborns following delivery

prior to hospital discharge; and (4) endorses Universal Photographic Newborn Screening as a national practice for newborn children.

435. RADIATION EXPOSURE COMPENSATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy H-455.994

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.

REFERENCE COMMITTEE E

501. FRAGRANCE REGULATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association recognize fragrance sensitivity as a disability where the presence of fragranced products can limit accessibility of healthcare settings (New HOD Policy); and be it further

RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind; and be it further

RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care; and be it further

RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization in the use of a "fragrance free" designation; and be it further

RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one's body.

502. TRIBALLY-DIRECTED PRECISION MEDICINE RESEARCH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-460.876

RESOLVED, that our American Medical Association support clinical funding supplements to the National Institutes of Health, the U.S. Food and Drug Administration, and the Indian Health Service to promote greater participation of the Indian Health Service, Tribal, and Urban Indian Health Programs in research.

503. UNREGULATED HEMP-DERIVED INTOXICATING CANNABINOIDS, AND DERIVED PSYCHOACTIVE CANNABIS PRODUCTS (DPCPS)
Introduced by Albert L. Hsu, MD, Delegate

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association work with other interested organizations to increase public awareness and promote education on the dangers of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids; and be it further

RESOLVED, that our AMA work with other interested organizations to advocate to close the loophole in the 2018 Farm bill that allows Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to be regulated as hemp; and be it further

RESOLVED, that our AMA work with other interested organizations to advocate for prohibition of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (unless and until properly tested in humans); and be it further

RESOLVED, that our AMA work with other interested organizations to advocate for further research on the health impacts of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, including the potential dangers of these products to children, pregnant women and other vulnerable populations; and be it further

RESOLVED, that our AMA report back on this issue at A-25.

504. FDA REGULATION OF BIOSIMILARS
Introduced by California

Resolution 504 was considered with Council on Science and Public Health 5.
See Council on Science and Public Health 5 which was adopted in lieu of Resolution 504.

RESOLVED, that our American Medical Association recognize that, by definition, Biosimilar medications are clinically equivalent to their reference Biologic and therefore do not need a designation of "interchangeability;" and be it further

RESOLVED, that our AMA support a rigorous approval process for Biosimilar medications and oppose the application of the redundant designation of "interchangeability" with the reference biologic drug; and it be further

RESOLVED, that AMA support the development of a model and a process for biologic and biosimilar medication prescribing that protects physician decision-making when a pharmacy-level substitution is not clinically appropriate; and be it further

RESOLVED, that our AMA support physician education on the clinical equivalence of Biosimilars, the FDA approval process and the post-market surveillance that is required.

505. MITIGATING THE HARMS OF COLORISM AND SKIN BLEACHING AGENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-250.987

RESOLVED, That our AMA work with all relevant stakeholders to affirm the longstanding and evolving evidence-based use of skin lightening agents; and be it further

RESOLVED, That our AMA work with the World Medical Association and other interested parties to advocate for public education regarding appropriate medical utilization of skin lightening agents and the harms of skin lightening motivated by cultural stigma and colorism.

506. SCREENING FOR IMAGE MANIPULATION IN RESEARCH PUBLICATIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support the creation of a nationally collaborative database of manipulated images from retracted publications to provide a test bank for researchers developing augmented intelligence-integrated image screening tools.

507. BAN ON DUAL OWNERSHIP, INVESTMENT, MARKETING OR DISTRIBUTION OF ADULT-USE CANNABIS, PSYCHEDELIC AGENTS, OR EMPATHOGENS BY MEDICAL COMPANIES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-95.897

RESOLVED, that our American Medical Association support a permanent ban on medical cannabis, psychedelic agent, and/or empathogenic agent companies (and their related holding conglomerates) from owning, investing in, distributing, or promoting recreational (or "adult use") cannabis, psychedelic agents, and/or empathogenic agents or any other activity relating to recreational use of cannabis, psychedelic agents, and/or empathogenic agents.

508. AMA TO SUPPORT REGULATIONS TO DECREASE OVERDOSES IN CHILDREN DUE TO INGESTION OF EDIBLE CANNABIS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association work with the Food and Drug Administration to strengthen how marijuana manufacturers can advertise their products, including regulations that ensure the packaging does not appeal to children; and be it further

RESOLVED, that our AMA propose public awareness campaigns aimed at informing the general population, especially parents and guardians, about the risks associated with edible cannabis and the importance of safe storage and handling; and be it further

RESOLVED, that our AMA emphasize the importance of childproof packaging for all cannabis products, along with advocating for stricter regulations to enforce this requirement.

509. ADDRESSING SARCOPENIA AND ITS IMPACT ON QUALITY OF LIFE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-25.997

RESOLVED, that our American Medical Association supports educational awareness targeting healthcare professionals, caregivers, and at-risk populations to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice; and be it further

RESOLVED, that our AMA (1) support nutritional interventions aimed at optimizing protein intake, essential amino acids, and micronutrients; (2) promote regular physical activity, including resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities and preferences; and be it further

RESOLVED, that our AMA support allocation of resources for research initiatives aimed at advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment modalities; and be it further

RESOLVED, that our AMA advocate for policy changes to support reimbursement for sarcopenia screening, diagnosis, and interventions; and be it further

RESOLVED, that our AMA collaborate with all stakeholders to integrate sarcopenia prevention and management into public health agendas and aging-related initiatives.

510. STUDY TO INVESTIGATE THE VALIDITY OF CLAIMS MADE BY THE MANUFACTURERS OF OTC VITAMINS, SUPPLEMENTS AND "NATURAL CURES"
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: POLICY H-150.954 REAFFIRMED
IN LIEU OF RESOLUTION 510

RESOLVED, that our American Medical Association study the growing problem of advertisements on OTC Vitamins, Supplements, and "Natural Cures" that claim health benefits and cures. With report back at A-25; and be it further

RESOLVED, that our AMA collaborate with all the specialties which are affected by these claims and gather scientific evidence showing benefits and false claims; and be it further

RESOLVED, that our AMA request that the FDA exercise its full scope of authority to protect our patients by removing all the advertisements containing false claims of medical cures.

511. NATIONAL PENICILLIN ALLERGY DAY AND PENICILLIN ALLERGY EVALUATION & APPROPRIATE DELABELING
Introduced by New England

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy H-100.941

RESOLVED, that National Penicillin Allergy Day, September 28, be recognized by the American Medical Association; and be it further

RESOLVED, that our AMA promote penicillin allergy evaluation and appropriate delabeling.

512. OPIOID OVERDOSE REVERSAL AGENTS WHERE AED'S ARE LOCATED
Introduced by New York

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy

RESOLVED, that our American Medical Association support the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations.

513. BIOTIN SUPPLEMENT PACKAGING DISCLAIMER
Introduced by New York

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy D-100.962

RESOLVED, that our American Medical Association support efforts to have over-the-counter biotin supplements provide a clear disclaimer on the bottle that states the possibility of lab test interference (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for greater awareness among both patients and physicians in regards to biotin megadose interference.

514. SAFETY WITH DEVICES PRODUCING CARBON MONOXIDE
Introduced by Texas

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy H-135.903

RESOLVED, that our American Medical Association support the United States Consumer Product Safety Commission in implementing higher safety standards for consumer products that produce carbon monoxide; and be it further

RESOLVED, that our AMA support public education efforts to minimize harm caused by carbon monoxide poisoning produced in enclosed spaces or too close to exterior openings.

515. ADVOCACY FOR MORE STRINGENT REGULATIONS/RESTRICTIONS ON THE DISTRIBUTION OF CANNABIS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
TITLE CHANGED
See Policy D-95.954

RESOLVED, that our American Medical Association study possible legislative, legal or regulatory means to make the cannabis industry responsible for increasing costs of medical and social care for people affected by the problems caused by cannabinoids similar to regulations for smoking cessation in the United States.

Resolution 516 was not considered

517. REGULATION OF NICOTINE ANALOGUE PRODUCTS
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-495.990

RESOLVED, that our American Medical Association oppose the development, production market and sales of nicotine analogue consumer products; and be it further

RESOLVED, that our AMA urge the Food and Drug Administration swiftly exert its authority to regulate all nicotine analogue products as drugs.

REFERENCE COMMITTEE F

601. HOLOCAUST REMEMBERANCE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-295.300

RESOLVED, that our American Medical Association provide educational in support of International Holocaust Remembrance Day (January 27) to physicians and medical trainees about the role of physicians in the Holocaust, and other human rights atrocities, and the role this played in developing the current Code of Medical Ethics.

602. RANKED CHOICE VOTING
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ADOPTED**
See Policy G-610.009

RESOLVED, that our American Medical Association study ranked choice voting for all elections within the House of Delegates.

603. PROTECTION OF HEALTHCARE AND HUMANITARIAN AID WORKERS IN ALL AREAS OF ARMED CONFLICT

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ALTERNATE RESOLUTION 603 ADOPTED**
IN LIEU OF RESOLUTION 603 AND 610
TITLE CHANGED
See Policy D-65.993 and H-520.985

RESOLVED, that our AMA supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel; and be it further

RESOLVED, that our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict; and be it further

RESOLVED, that our AMA reaffirm AMA Policy D-65.993, War Crimes as a Threat to Physicians' Humanitarian Responsibilities.

604. CONFRONTING AGEISM IN MEDICINE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-65.978 and H-65.939

RESOLVED, that our American Medical Association adopt the following definition of ageism based on the World Health Organization (WHO) and AGE Platform Europe: "Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age; structural ageism is the way in which society and its institutions sustain ageist attitudes, actions or language in laws, policies, practices or culture"; and be it further

RESOLVED, that our AMA establish a definition of "age equity," and consider adoption of the AGE Platform Europe vision: "Age equity is an inclusive society, based on well-being for all, solidarity between generations and full entitlement to enjoy life, participate in and contribute to society. At the same time, each person's rights and responsibilities throughout their life course have to be fully respected"; and be it further

RESOLVED, that our AMA will review and amend policies regarding discrimination, bias and microaggressions, and add age or ageism during the sunset review process; and be it further

RESOLVED, that our AMA routinely incorporate intersectional approaches to ageism; and be it further

RESOLVED, that our AMA conduct ongoing (1) advocacy for hospital and regulatory policy changes focused on individual physicians' care quality data rather than their age; and (2) educational outreach to AMA members (i.e. starting with a Prioritizing Equity episode panel discussion to be posted on Ed HubTM for CME, as a video and podcast, and promoted through the UCEP/GCEP channels); and be it further

RESOLVED, that our AMA work with the World Medical Association (WMA) and other interested stakeholders to have AMA's work significantly inform the global health organization's work on ageism.

605. WALKING THE WALK OF CLIMATE CHANGE
Introduced by Senior Physicians Section

Resolution 605 considered with Board of Trustees Report 25.
See Board of Trustees Report 25.

RESOLVED, that our American Medical Association Board of Trustees present to the House of Delegates at Interim 2024 a detailed timeline as to when and how to achieve our organizational carbon neutrality; and be it further

RESOLVED, that our AMA staff study AMA-related corporate travel with respect to minimizing carbon emissions and/or mitigating or off-setting such emissions; and be it further

RESOLVED, that our AMA adopt a policy for plant-based menus as the default option when planning meeting venues with an opt-out alternative as appropriate.

606. CREATION OF AN AMA COUNCIL WITH A FOCUS ON DIGITAL HEALTH TECHNOLOGIES AND AI
Introduced by New England

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-615.998

RESOLVED, that our American Medical Association establish a task force by I-24 focused on digital health, technology, informatics, and augmented/artificial intelligence with transition of this task force to a new council and report back A-25 on this transition.

607. APPEALING TO OUR AMA TO ADD CLARITY TO ITS MISSION STATEMENT TO BETTER MEET THE NEED OF PHYSICIANS, THE PRACTICE OF MEDICINE AND THE PUBLIC HEALTH
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association amends its mission's statement from "to promote the art and science of medicine and the betterment of public health" to "to empower physicians to better care for their patients, advance the art and science of medicine, and promote the betterment of physicians and the public health."

608. THE AMERICAN MEDICAL ASSOCIATION DIVERSITY MENTORSHIP PROGRAM
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-200.969

RESOLVED, that our American Medical Association establish a diversity mentorship program to connect volunteer mentors with residents, fellows, and medical student mentees who are underrepresented in medicine; and be it further

RESOLVED, that the AMA encourages state, county, and specialty medical societies to develop mentorship programs that encourage people from under-represented groups to pursue careers in medicine.

609. STANDARDIZATION OF THE ENDORSEMENT PROCESS
Introduced by Texas

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
See Policy G-610.090

RESOLVED, that our American Medical Association require all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner; and be it further

RESOLVED, that our AMA then post this information on the election website in a timely manner, with the information being easily digestible and accessible; and be it further

RESOLVED, that our AMA not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle; and be it further

RESOLVED, that our AMA create a specific period (similar to virtual elections) during which endorsements may be sought.

610. OPPOSITION TO COLLECTIVE PUNISHMENT
Introduced by Resident and Fellow Section

Resolution 610 considered with Resolution 603.
See Resolution 603.

RESOLVED, that our American Medical Association (AMA) oppose collective punishment tactics—including restrictions on access to food, water, electricity, and healthcare—as tools of war; and be it further

RESOLVED, that our AMA oppose the use of United States funding to any entities that (1) do not uphold international law; or (2) commit or condone war crimes; and be it further

RESOLVED, that our AMA condemn the use of United States resources to enforce collective punishment on civilians, including in Gaza; and be it further

RESOLVED, that our AMA advocate for federal funding and support for national and international agencies and organizations that provide support for refugees, such as the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Reliefs and Works Agency for Palestinian Refugees in the Near East (UNRWA).

REFERENCE COMMITTEE G

701. OPPOSITION TO THE HOSPITAL READMISSIONS REDUCTION PROGRAM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy D-385.941

RESOLVED, that our American Medical Association oppose the Hospital Readmissions Reduction Program.

702. THE CORPORATE PRACTICE OF MEDICINE, REVISITED
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-215.982

RESOLVED, That our American Medical Association revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.

703. UPHOLDING PHYSICIAN AUTONOMY IN EVIDENCE-BASED OFF-LABEL PRESCRIBING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-120.915

RESOLVED, that our American Medical Association (AMA) advocates for transparency, accountability, and fair pricing practices in pharmaceutical pricing; and be it further

RESOLVED, that our AMA condemns interference with a physician's ability to prescribe clinically appropriate medication without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices.

704. PEDIATRIC READINESS IN EMERGENCY DEPARTMENTS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policies D-220.968 and H-130.939

RESOLVED, that our American Medical Association reaffirm H-130.939 acknowledging the importance of pediatric readiness in all emergency departments with awareness of the guidelines for Pediatric Readiness in the Emergency Department and stand ready to care for children of all ages; and be it further

RESOLVED, that our American Medical Association (AMA) work with appropriate state and national organizations to advocate for the development and implementation of pediatric-ready facility recognition programs.

705. TIME-LIMITED DIRECT PATIENT CARE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
TITLE CHANGED
See Policy D-450.951

RESOLVED, that our American Medical Association ask that the appropriate AMA Council conduct a study of the adverse effects of direct patient care time limitations on the quality of care provided, as well as on patient and physician dissatisfaction, with a report back at the next AMA Annual Meeting.

706. AUTOMATIC PHARMACY-GENERATED PRESCRIPTION REQUESTS
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy D-120.923

RESOLVED, that our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient's surrogates, or automatically by the pharmacy.

707. ALTERNATIVE FUNDING PROGRAMS
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-110.983

RESOLVED, that our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs.

708. MEDICOLEGAL DEATH INVESTIGATIONS
Introduced by National Association of Medical Examiners

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-85.948

RESOLVED, that our American Medical Association supports the independent authority of physicians to provide accurate and transparent postmortem assessments and death investigation reporting in a manner free from undue influence; and be it further

RESOLVED, that our AMA advocate with state and federal governments to ensure laws and regulations do not compromise a physician's ability to use their medical judgement in the reporting of postmortem assessments and medicolegal death investigations.

709. IMPROVEMENTS TO PATIENT FLOW IN THE U.S. HEALTHCARE SYSTEM
Introduced by American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-160.905

RESOLVED, that our American Medical Association work with relevant stakeholders and propose recommendations to appropriate entities to improve patient flow and access to care throughout multiple environments in the U.S. healthcare system.

710. THE REGULATION OF PRIVATE EQUITY IN THE HEALTHCARE SECTOR
Introduced by American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-160.904 and H-215.981

RESOLVED, That our American Medical Association propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected; and be it further

RESOLVED, that our AMA modify policy H-215.981, Corporate Practice of Medicine, by addition:

4. Our AMA will work with state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the healthcare sector such that physician autonomy in clinical care is preserved and protected.

711. INSURER ACCOUNTABILITY WHEN PRIOR AUTHORIZATION HARMS PATIENTS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: RESOLUTION 711 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 720
See Policy D-320.974

RESOLVED, that our American Medical Association advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.

712. FULL TRANSPARENCY - EXPLANATION OF BENEFITS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-320.973

RESOLVED, that our American Medical Association advocate that the minimum information included in an explanation of benefits, whether sent to the patient or the physician practice, includes the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints, in a manner that protects patient privacy.

713. TRANSPARENCY – NON-PAYMENT FOR SERVICES TO PATIENTS WITH ACA EXCHANGE PLANS WITH UNPAID PREMIUMS
Introduced by New York

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-185.938 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association will advocate for legislation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, or electronic transaction, including but not limited to X12 270/271; and be it further

RESOLVED, that our AMA will advocate for legislation or regulation to require that health plans inform healthcare providers whether the plan premium has been paid and whether the account is late on payment as part of benefit verification, whether by phone, fax, electronic transaction including but not limited to X12 270/271; and be it further

RESOLVED, that our AMA will advocate that X12 includes plan premium payment status as part of X12 270/271 standard transaction code updates; and be it further

RESOLVED, that our AMA will report on the status of this resolution at the 2025 Annual Meeting.

714. AUTOMATIC DOWNCODING OF CLAIMS
Introduced by Texas

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-320.972

RESOLVED, that our American Medical Association vigorously oppose health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.

RESOLVED, that our AMA support that, after review of the patient's medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes; and be it further

RESOLVED, that our AMA advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim; and be it further

RESOLVED, That our AMA further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

715. ELECTRONIC MEDICAL RECORDS SUBMISSION
Introduced by Texas

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-478.995, H-315.979 AND H-320.944
REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, that our American Medical Association support requiring insurers and their third parties to provide a secure, standardized, no-cost, easily accessible, and user-friendly mechanism to allow physicians to submit requested medical records and other documents electronically on an online portal, in addition to any fax and mail options; and be it further

RESOLVED, that our AMA support physicians' ability to track and see the status of the medical record request on the portal; and be it further

RESOLVED, that our AMA advocate for legislation requiring insurers to accept electronic submission of medical records requested by insurers and/or their third parties using an accessible, standardized, and user-friendly mechanism that also makes available tracking and status of the request.

716. IMPACT OF PATIENT NON-ADHERENCE ON QUALITY SCORES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-450.950

RESOLVED, that our American Medical Association study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized, identify equitable and actionable solutions, and report back at Annual 2025.

717. MENTORSHIP TO COMBAT PRIOR AUTHORIZATION
Introduced by Private Practice Physicians Section

Resolution 717 considered with Resolution 721.
See Resolution 721.

RESOLVED, Resolved, that our American Medical Association study the development of a template for a mentorship program for early career physicians as a means to reduce excessive healthcare costs, with a report back by Annual 2025; and be it further

RESOLVED, that our AMA develop modules of education centered on the economics of utilization of testing, pharmaceuticals, and procedures in various categories of common and exceptional medical care ; and be it further

RESOLVED, that our AMA work with affected stakeholders, including government legislators and regulators, pharmaceutical and business interests, healthcare systems, and patient representatives as well as physicians on substitution of mentorship for frequent prior authorization requests.

718. TRANSPARENCY AT THE PHARMACY COUNTER
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-120.922

RESOLVED, that our American Medical Association advocate for legislation or regulation that mandates that pharmacies, whether physical or mail-order, must inform patients about their prescriptions, to include at a minimum:

a) The dosage and schedule of treatments as written by the prescriber

b) Any restriction or alteration of the prescriber's intent due to third party or pharmacy intervention, with the stated justification

c) Details of other avenues to obtain the original prescription, including out of pocket options, with comparative costs.

719. SUPPORT BEFORE, DURING, AND AFTER HOSPITAL CLOSURE OR REDUCTION IN SERVICES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-215.980

RESOLVED, that our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should:

a) Assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area;

b) Allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time;

c) Ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage; and be it further

RESOLVED, that our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures, change in ownership, or significant reductions in services via provision of information, resources, and effective, actionable advocacy.

720. THE HAZARDS OF PRIOR AUTHORIZATION
Introduced by Organized Medical Staff Section

Resolution 720 considered with Resolution 711.
See Resolution 711.

RESOLVED, that our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization; and be it further

RESOLVED, that our AMA support that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization; and be it further

RESOLVED, that our AMA support that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

721. DEVELOPING PHYSICIAN RESOURCES TO OPTIMIZE PRACTICE SUSTAINABILITY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: RESOLUTION 721 ADOPTED
IN LIEU OF RESOLUTION 717
See Policy D-200.968

RESOLVED, that our American Medical Association develop a toolkit for physicians as a means to reduce excessive healthcare costs as well as improve physician practice sustainability and wellbeing, with a report back by Annual 2025.