AMA
AMERICAN MEDICAL ASSOCIATION
ama-assn.org
(312) 464-5000

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2024 Meeting

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

Recommendations key
Instructions for the delegate and alternate delegate are designated as follows:

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

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

Note: Items highlighted in blue have been placed on the Resolutions Not for Consideration list.

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

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	CCB	CCB Report 01 – Resolution Deadline Clarification	RECOMMENDATIONS The Council on Constitution and Bylaws recommends that the following recommendation be adopted, and that the balance of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover. 1) That our AMA Bylaws be amended by insertion and deletion as follows: **2.11.3 Introduction of Business.** **2.11.3.1 Resolutions.**	Delegate instructed to strongly support.

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			2.11.3.1.1 On-Time Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 45 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions. **2.11.3.1.1.1 AMA Sections.** Resolutions presented from ~~the business~~ meetings of the AMA Sections convened prior to the coinciding House of Delegates meeting but after the 45 day on-time deadline may be presented for consideration by the House of Delegates upon adoption by the Section and no later than the commencement ~~recess~~ of the House of Delegates opening session to be accepted as regular business. Section ~~R~~resolutions presented after the commencement ~~recess~~ of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.3. **2.11.3.1.2 Late Resolutions**. Late resolutions may be presented by a delegate or organization represented in the House of Delegates any time after the 45-day resolution deadline until the commencement of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting. **2.11.3.1.3 Emergency Resolutions**. Resolutions of an emergency nature may be presented by a delegate any time after the commencement of the opening session of the House of Delegates. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be ~~presented to~~ considered by the House of Delegates without ~~consideration~~ deliberation by a reference committee. ~~A simple majority vote of the delegates present and voting shall be required for adoption~~.	
2	CCB	CEJA Report 02 – Protecting Physicians Who Engage in	RECOMMENDATION In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, “Contracts to Deliver Health Care Services,”	Delegate instructed to support.

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		Contracts to Delivery Health Care Services	be amended by addition and deletion as follows and the remainder of this report be filed: While profitmaking is not inherently unethical, no part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients. As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy. When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:	

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			(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement: (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance; (ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk; (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment; (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients; (v) is transparent and permits disclosure to patients; (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing. (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards. When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should: (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism. (d) Advocate that contract provisions affecting practice align with the	

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			professional and ethical obligations of physicians and negotiate to ensure that alignment. (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.	
3	CCB	Res. 002 – Anti-Doxxing Data Privacy Protection (Women's Physician Section)	RESOLVED, that our American Medical Association support physicians and healthcare providers that provide reproductive and gender-affirming care who experience doxxing, support nondiscrimination and privacy protection for employees, and availability of resources on doxing (New HOD Policy) RESOLVED, that our AMA work with partners to support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information for physicians who provide reproductive and gender-affirming care (Directive to Take Action) RESOLVED, that our AMA encourage institutions, employers, and state medical societies to provide legal resources and support for physicians who provide reproductive and gender-affirming care who are affected by doxing (New HOD Policy) RESOLVED, that our AMA encourage institutions, employers, and medical societies to provide training and education on the issue of doxxing. (New HOD Policy)	Delegate instructed to support, but consider opportunities for amendments to make the resolution more broadly applicable beyond only physicians providing reproductive and gender-affirming care.
4	CCB	Res. 004 – Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients (LGBTQ)	RESOLVED, that our American Medical Association amend policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows: **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967** Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically	Delegate instructed to listen.

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			relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (~~4~~5) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care; (Modify Current HOD Policy) RESOLVED, that our AMA supports the use of the term "chosen name" over "preferred name," recognizing the value of the term "chosen name" to transgender and gender-diverse patients (New HOD Policy)	
5	CCB	Res. 009 – Opposition to Creation or Enforcement of Civil Litigation,	RESOLVED, that our American Medical Association affirms that civil causes of action in healthcare should be limited to causes of action that address alleged violations of a physician's duty to meet the standard of care in the treatment of patients. (New HOD Policy)	Delegate instructed to listen.

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		Commonly Referred to as Civil Causes of Action (Kansas)		
6	B	BOT Report 01 – Augmented Intelligence Development, Deployment, and Use in Health Care	RECOMMENDATION The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed: AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE 1) General Governance a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent. b) Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration. c) Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient. d) AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes. e) Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)] f) AI risk management should minimize potential negative impacts of health	Delegate instructed to listen and consult with the IPPS Delegate (IPPS has done a significant amount of work with this issue and report).

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			care AI systems while providing opportunities to maximize positive impacts. g) Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model. h) Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff. i) Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)] 2) When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care a) Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient. i) AI disclosure should align and meet ethical standards or norms. ii) Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden. iii) When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed	

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			and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request. iv) When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record. b) AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review. c) When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties. d) The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content. 3) What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies a) When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization: i) Regulatory approval status. ii) Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology. iii) Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use. iv) Intended population and intended practice setting. v) Clear description of any limitations or risks for use, including possible	

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			disparate impact. vi) Description of how impacted populations were engaged during the AI lifecycle. vii) Detailed information regarding data used to train the model: (1) Data provenance. (2) Data size and completeness. (3) Data timeframes. (4) Data diversity. (5) Data labeling accuracy. viii) Validation Data/Information and evidence of: (1) Clinical expert validation in intended population and practice setting and intended clinical outcomes. (2) Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error. (3) Algorithmic validation. (4) External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation. (5) Comprehensiveness of data and steps taken to mitigate biased outcomes. (6) Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings. (7) Post-market surveillance activities aimed at ensuring continued safety, performance, and equity. ix) Data Use Policy: (1) Privacy. (2) Security. (3) Special considerations for protected populations or groups put at increased risk. x) Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training. xi) Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review. b) Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not	

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			disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939] 4) Generative Augmented Intelligence a) Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement). b) Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of: i) Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response. ii) Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations. iii) Lack of regulatory or clinical oversight to ensure performance of the tool. iv) Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes. v) Data privacy. vi) Cybersecurity. vii) Physician liability associated with the use of generative AI tools. c) Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)] d) Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools. e) Clinicians should be aware of the risks of patients engaging with generative	

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			AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice. f) Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content. g) Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential. 5) Physician Liability for Use of Augmented Intelligence-Enabled Technologies a) Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939] i) Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability. ii) Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users. iii) Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm. b) When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question. 6) Data Privacy and Augmented Intelligence a) Entity Responsibility: i) Entities, e.g., AI developers, should make information available about the	

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			intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits. ii) Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool. iii) Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy. b) User Education: i) Users should be provided with training specifically on generative AI. Education should address: (1) Legal, ethical, and equity considerations. (2) Risks such as data breaches and re-identification. (3) Potential pitfalls of inputting sensitive and personal data. (4) The importance of transparency with patients regarding the use of generative AI and their data. [See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)] 7) Augmented Intelligence Cybersecurity a) AI systems must have strong protections against input manipulation and malicious attacks. b) Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior. c) Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information. d) Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting	

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			suspicious AI behavior or outputs. 8) Mitigating Misinformation in AI-Enabled Technologies a) AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems. b) Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated. c) Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems. d) Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users. e) Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI. f) Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences. 9) Payor Use of Augmented Intelligence and Automated Decision-Making Systems a) Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their	

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			physician in a way that is easy to understand. b) Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients. c) Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias. d) Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions. e) Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized. f) Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant	

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			information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used). g) Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws. (New HOD Policy)	
7	B	BOT Report 02 – On-Site Physician Requirements for Emergency Departments	RECOMMENDATIONS The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed: 1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open. (New HOD Policy) 2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in	Delegate instructed to strongly support, seek out ways to tighten and strengthen the second resolve clause.

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			developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care. (New HOD Policy)	
8	B	BOT Report 03 – Stark Law Self-Referral Ban	RECOMMENDATION The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed. 1. That our American Medical Association reaffirm AMA Policies H-140.861, “Physicians Self-Referral,” D-270.995, “Physician Ownership and Referral for Imaging Services,” and H-385.914, “Stark Law and Physician Compensation,” be reaffirmed. (Reaffirm HOD Policy) 2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)	Delegate instructed to strongly support.
9	B	BOT Report 04 – Addressing Work Requirements for J-1 Visa Waiver Physicians	RECOMMENDATIONS The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 217-I-23, and the remainder of the report be filed: Our American Medical Association supports federal visa and visa waiver policies that include time within the federally mandated work week requirements for direct patient care, administrative tasks, professional development opportunities, and other professional responsibilities. (New HOD Policy)	Delegate instructed to strongly support.

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10	B	BOT Report 09 – Corporate Practice of Medicine Prohibition	RECOMMENDATIONS: The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine," be amended by addition and the remainder of the report be filed: 1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine. (Reaffirm HOD Policy) 2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine. (New HOD Policy) 3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. (New HOD Policy) 4. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations. (Reaffirm HOD Policy) 5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues. (Directive to take action) 6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy ~~in clinical care~~ and operational authority ~~is~~ are preserved and protected. (Modify Current HOD Policy) 7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of	Delegate instructed to strongly support.

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			prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices. (New HOD Policy)	
11	B	Res. 201 – Boarding Patients in the Emergency Room (Tennessee)	RESOLVED, that our American Medical Association immediately collaborate with stakeholders such as hospitals, insurance companies, CMS, and joint commission to resolve ~~this issue~~ the boarding of patients in hospital emergency rooms (Directive to Take Action) New Title: Boarding Patients in the Hospital Emergency Room RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and appropriate care for patients and the emergency room and those admitted but still physically located in the emergency room to decrease patient harm and physician and nurse burnout. (Directive to Take Action)	Delegate instructed to support amendments to clarify that the clauses refer to emergency rooms.
12	B	Res. 204 – Support for Physician-Supervised Community Paramedicine Programs (Medical Student Section)	RESOLVED, that our American Medical Association support federal and state efforts to establish, expand, and provide coverage for community paramedicine programs supervised by physicians, especially in rural areas. (New HOD Policy)	Delegate instructed to listen.
13	B	Res. 208 – Medicare Part B Enrollment and Penalty Awareness (Senior Physicians Section)	RESOLVED, that our American Medical Association review the current penalties for declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services (CMS), and advocate for changes to improve awareness of the risk and financial burdens associated with discontinuing coverage before reaching age 65 (Directive to Take Action) RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in insurance coverage or permanent increases in Part B premiums (Directive to Take Action) RESOLVED, that our AMA advocate for enhanced public awareness regarding	Delegate instructed to support resolves 1-3, withhold support from resolve 4.

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			the risks of not enrolling in Medicare Part B, and support making information about these risks more accessible and widely available to prevent lifetime penalties (Directive to Take Action) RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)	
14	B	Res. 214 – Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access (American College of Obstetrics and Gynecologists)	RESOLVED, that our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit (New HOD Policy) RESOLVED, that our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities (New HOD Policy) RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians ~~and advanced practice providers~~ and improve perinatal health outcomes in rural communities (New HOD Policy) RESOLVED, that our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities (New HOD Policy).	Delegate instructed to support with amendment as illustrated.
15	B	Res. 215 – Advocating for Federal and State Incentives for Recruitment and Retention of Physicians	RESOLVED, that our American Medical Association advocate for increased federal and state funding for loan forgiveness for physicians who commit to practice and reside in rural and underserved areas for a meaningful period of time (Directive to Take Action)	Delegate instructed to support.

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		to Practice in Rural Areas (American College of Obstetricians and Gynecologists)	RESOLVED, that our AMA urge Congress and State legislatures to establish retention bonus programs for physicians who maintain practice in rural areas for extended periods, with increasing bonuses for longer commitments (Directive to Take Action) RESOLVED, that our AMA advocate for the expansion and sustainable funding of residency and graduate medical education slots in rural areas, as well as opportunities for exposure to rural health care such as through clinical rotations in rural areas, to increase the likelihood of physicians practicing in these communities after training. (Directive to Take Action)	
16	B	Res. 218 – Time Sensitive Credentialing of New Providers with an Insurance Carrier (New Jersey)	RESOLVED, that our American Medical Association urge the US Department of Labor to establish uniform provider credentialing standards for Third Party Administrator's (TPA's) serving ERISA Plans to include the following : that when a credentialing application is submitted, the insurance carrier must respond in writing within five business days whether the application is complete and acceptable, and if incomplete the carrier must send notice to the provider indicating what additional information is needed for completion of the process, and acknowledge the completion of a successfully completed application within ten business (Directive to Take Action) RESOLVED, that our AMA urge the US Department of Labor to require Third Party Administrators to send a written notice to applicants within 45 days, regarding their credentialing decision and after 45 days, an applicant is deemed to have been automatically credentialled and enrolled to be eligible for payment of services, even if the payer fails to acknowledge the applicant. (Directive to Take Action)	Delegate instructed to support.
17	B	Res. 219 – Advocate to Continue Reimbursement for Telehealth/Telemedicine Visits Permanently (New York)	RESOLVED, that our American Medical Association advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers. (Directive to Take Action)	Delegate instructed to support.

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18	B	Res. 225 – Elimination of Medicare 14-Day Rule (Association for Clinical Oncology)	RESOLVED, that our American Medical Association actively lobby the federal government to readdress and change laboratory date of service rules under Medicare, e.g. the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that complex laboratory services performed on pathologic specimens collected from an inpatient hospital procedure be paid separately from inpatient bundled payments, consistent with Outpatient rules. (Directive to Take Action).	Delegate instructed to support.
19	B	Res. 226 – Information Blocking Rule (Association for Clinical Oncology)	RESOLVED, that our American Medical Association supports the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy) RESOLVED, that our AMA supports the requirement of review of report and result information by the ordering physician or physician surrogate prior to release of medical information to the patient (New HOD Policy) RESOLVED, that our AMA supports expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy) RESOLVED, that our AMA advocates for expansions to the harm exception to the Information Blocking Rule and for the requirement of review by the ordering physician or surrogate prior to the application of the Information Blocking Rule provisions. (Directive to Take Action).	Delegate instructed to support.
20	B	Res. 227 – Medicare Payment Parity for Telemedicine Services (American College of Rheumatology)	RESOLVED, that our American Medical Association advocate for Medicare to reimburse providers for telemedicine-provided services at an equal rate as if the services were provided in-person. (Directive to Take Action)	Delegate instructed to support.

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21	C	Res. 302 – Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates (Resident and Fellow Section)	RESOLVED, that our American Medical Association amend Policies for Parental, Family and Medical Necessity Leave H-405.960 by addition to read as follows: 5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed with eligibility beginning at the start of employment without a waiting period. (Modify Current HOD Policy)	Delegate instructed to support.
22	C	Res. 303 – Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter (Resident and Fellow Section)	RESOLVED, that our American Medical Association supports transparency and access to information about medical training program unionization status (New HOD Policy) RESOLVED, that our AMA creates and maintains an up-to-date unionization filter on FREIDA™ for trainees to make informed decisions during the Match. (Directive to Take Action)	Delegate instructed to support, if extracted.
23	F	CLRPD Report 01 – Academic Physicians Section Five-Year Review	RECOMMENDATIONS The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2029 with the next review no later than the 2029 Interim Meeting.	Delegate instructed to support.
24	F	BOT Report 16 – AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	RECOMMENDATIONS The AMA recognizes that engagement by the organizations who send representatives to our HOD meetings to participate in the policy-making process is essential to the strength of organized medicine. Your Board of Trustees is committed to supporting attendance at AMA HOD meetings,	Delegate instructed to support/listen and seek amendment for clarity for an ongoing report if needed.

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			providing immediate financial relief on a short-term emergency basis, and developing a plan for long-term sustainable participation. Therefore, your Board of Trustees recommends that Resolution 606-A-23 not be adopted and the remainder of this report be filed.	
25	F	Res. 601 – Expanding AMA Meeting Venue Options (Texas)	RESOLVED, that our American Medical Association rescind Policy G-630.140 Item 4. (Rescind HOD Policy)	Delegate instructed to listen.
26	F	Res. 607 – AMA House of Delegates Venues (New York)	RESOLVED, that our American Medical Association retain the ability to choose any location within the continental United States to hold the Annual Meeting (Directive to Take Action) RESOLVED, that our AMA Policy G630.140 Item 4 be rescinded (Rescind HOD Policy) RESOLVED, that our AMA Board of Trustees will employ or contract any services that may reduce or alleviate concerns about risk factors related to a particular location venue (Directive to Take Action) RESOLVED, that our AMA Board of Trustees re-examine previously used and explore potentially new venues for future Interim meetings. (Directive to Take Action)	Delegate instructed to listen.
27	J	BOT Report 15 – Public Metrics for Hospitals and Hospital Systems	RECOMMENDATIONS The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 715-A-23 and the remainder of the report be filed. 1. That our AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment.	Delegate instructed to support and listen.

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28	J	CMS Report 01 – Nonprofit Hospital Charity Care Policies	RECOMMENDATIONS The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 802-I-23, and the remainder of the report be filed: 1) That our American Medical Association (AMA) support that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy) 2) That our AMA support efforts to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy) 3) That our AMA support development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy) 4) That our AMA support a standardized definition of what is considered a “community benefit” when evaluating community health improvement activities. (New HOD Policy) 5) That our AMA support the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy) 6) That our AMA support expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy) 7) That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)	Delegate instructed to support.

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29	J	CMS Report 02 – Unified Financing Health Care System	RECOMMENDATIONS The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. (Directive to Take Action) 2. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access. (Reaffirm HOD Policy)	Delegate instructed to support and listen.
30	J	CMS Report 03 – Time-Limited Patient Care	RECOMMENDATIONS The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed: 1. That our American Medical Association (AMA) support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free	Delegate instructed to support.

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			from undue influence from outside entities such as, but not limited to, payers, administrators, and health care systems. (New HOD Policy) 2. That our AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. (New HOD Policy) 3. That our AMA reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy H-405.957 that describes AMA efforts to study, promote, and educate on physician well-being and to prevent physician burnout. (Reaffirm HOD Policy) 6. Rescind Policy D-450.951, as having been completed with this report. (Rescind HOD Policy)	
31	J	CMS Report 04 – Biosimilar Coverage Structures	RECOMMENDATIONS The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our American Medical Association (AMA) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician. (New HOD Policy) 2. That our AMA support patient education regarding biosimilars and their	Delegate instructed to support.

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			safety. (New HOD Policy) 3. That our AMA reaffirm Policy H-110.987, which works to ensure that prescription medications are affordable and accessible to patients. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-110.997 which supports the freedom of physicians in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy D-125.989, which outlines efforts to ensure that physicians are able to transition patient to biosimilar medications with coverage from payers. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy H-125.972 which details efforts to encourage physician education related biosimilars. (Reaffirm HOD Policy)	
32	J	Res. 801 – Reimbursement for Managing Portal Messages (Tennessee)	RESOLVED, that our American Medical Association immediately collaborate with payers to seek adequate reimbursement for professional time spent answering questions on the patient portal not related to a recent visit (Directive to Take Action) RESOLVED, that our AMA continue to advocate for physicians to receive adequate compensation or seek relief from overreaching administrative tasks that take physicians' time away from direct patient care during our present climate of ever-increasing unpaid and unfunded mandates on their time.	Delegate instructed to support.
33	J	Res. 802 – Address Physician Burnout with Inbox Management Resources and Increased Payment (Texas)	RESOLVED, that our American Medical Association develop additional inbox management resources (Directive to Take Action RESOLVED, that our AMA advocate for increasing the relative value unit for inbox management recognizing that it is asynchronous care that provides value and reduces overall health care costs (Directive to Take Action)	Delegate instructed to support.

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			RESOLVED, that our AMA advocate for electronic health record tools that calculate physician time spent in the inbox. (Directive to Take Action)	
34	J	Res. 810 – Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians (Mississippi)	RESOLVED, that our American Medical Association advocate for the Centers for Medicare & Medicaid Services to provide (or cause their associated carriers to provide) a hyperlink (such as a QR code) to a digital, well-organized, and searchable formulary located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters. (Directive To Take Action)	Delegate instructed to listen.
35	J	Res. 814 – Legislation for Physician Payment for Prior Authorization (American Association of Clinical Urologists)	RESOLVED, that our American Medical Association initiates prior authorization legislation aimed at Medicare Advantage plans, state Medicaid programs as well as commercial payers, via model legislation, that allows for fair reimbursement for physician's time and that of their office staff when dealing with prior authorization. (Directive to Take Action)	Delegate instructed to support.
36	J	Res. 815 – Addressing the Crisis of Pediatric Hospital Closures and Impact on Care (Society of Critical Care Medicine)	RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units as a critical threat to children's health care access and quality (New HOD Policy) RESOLVED, that our AMA advocate for federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action) RESOLVED, that our AMA work with relevant organizations, for example the American Academy of Pediatrics, American Hospital Association, Children's Hospital Association, and National Rural Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities (Directive to Take Action) RESOLVED, that our AMA build a national coalition with the American Hospital	Delegate instructed to strongly support.

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			Association and other like-minded organizations to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric inpatient and critical care. (Directive to Take Action)	
37	J	Res. 818 – Payment for Pre-Certified/Preauthorized Procedures (New York)	RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment for care which has been pre-certified by an insurer should be banned, except when false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy) RESOLVED, that our AMA continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan. (Directive to Take Action)	Delegate instructed to support.
38	J	Res. 819 – Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Service Using High-Cost Supplies (Society for Cardiovascular Angiography and Interventions)	RESOLVED, that our American Medical Association study options to reform the Medicare Physician Fee Schedule by (1) removing high-cost supplies from the Medicare Physician Fee Schedule by establishing a new office-based facility setting to pay separately for the technical reimbursement of physician services using high-cost supplies (2) removing high-cost radiation therapy equipment from the Medicare Physician Fee Schedule by establishing a new case rate model for radiation oncology. (Directive to Take Action)	Delegate instructed to listen.

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39	J	Res. 824 – Ophthalmologists Required To Be Available for Level I & II Trauma Centers (American Academy of Ophthalmology)	RESOLVED, that our American Medical Association work with the American College of Surgeons and the American Trauma Society to specifically name Ophthalmology as a requirement for Level I & II Trauma Centers (Directive to Take Action) RESOLVED, that our AMA work with the American College of Surgeons and the American Trauma Society to ensure that during the verification process it has to be insisted that there is availability of Ophthalmology Trauma coverage. (Directive to Take Action)	Delegate instructed to support.
40	K	CSAPH Report 02 – Drug Shortages: 2024 Update	RECOMMENDATIONS The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 922-I-23, and that the remainder of the report be filed: 1. That Policy H-100.956, “National Drug Shortages,” be amended by addition and deletion to read as follows: 1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. 2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion. 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage. 4. Our AMA will advocate that the U.S. Food and Drug Administration (FDA)	Delegate instructed to support and listen.

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			and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant. 5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages. 6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission (FTC) to oversee and regulate such forces. 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons. 8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history. 9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the FTC consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. 11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in	

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			product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages. 12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages. 13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages. 14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing~~.~~, and supports the use of incentives such as prioritized regulatory review, reduction of user fees, and direct grant opportunities for manufacturers seeking to invest in manufacturing processes. 15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling. 16. Our AMA encourages electronic health records vendors to make changes to their systems to ease the burden of making drug product changes. 17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities. 18. Our AMA urges DHHS and the U.S. Department of Homeland Security to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan. 19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients. 20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing	

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			redundancy, and maintaining a minimum number of manufacturers for essential medicines. 21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk. 22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans. 23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary. 24. Our AMA opposes increasing drug prices or waiving fee exemptions in a manner that incentivizes a drug manufacturer to have its drug be declared in shortage. 25. Our AMA opposes the use of punitive fees on physician practices that do not maintain buffer supplies of drugs. 26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies advertising drugs actively in shortage, particularly when targeted to new patients. (Modify Current Policy) 2. That the following new HOD policy be adopted: Artificial Drug Shortages Limiting Access to Medications Our AMA will: 1. Oppose laws, regulations, or business practices which create artificial scarcity of drugs, such as limitations on pharmacy procurement or restrictions on which pharmacies a patient can use, which prevent the filling of an otherwise valid prescription from their physician; 2. Advocate for pharmacies and distributors subject to the national opioid litigation settlement to make public the specific metrics, formulas, data sources, algorithms, thresholds and other policies and analyses that are used to delay or deny orders to pharmacies, restrict physicians' prescribing privileges and other actions that impede patients' access to medication; and	

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			3. Advocate for pharmacies and distributors to provide physicians with all due process rights and opportunities to contest any decision to restrict a physician's prescribing privileges based on a pharmacy or distributor metric, formula, algorithm or other policy before such restriction is put into effect. (New HOD Policy) 3. That policies H-120.923, "Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions", H-120.920, "Access to Medications", and D-110.987, "The Impact of Pharmacy Benefit Managers on Patients and Physicians" be reaffirmed. (Reaffirm HOD Policy)	
41	K	Res. 904 – Regulation of Ionized Radiation Exposure for Healthcare Workers (Women's Physician Section)	RESOLVED, that our American Medical Association encourage public and private healthcare institutions to ensure more comprehensive coverage of different body types by providing PPE that more completely protects employees of all genders and pregnancy statuses, such as lead and lead-free aprons with capped sleeves, axillary supplements, and maternity aprons. (New HOD Policy)	Delegate instructed to support.
42	K	Res. 907 – Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans Within Those Hospitals (Academic Physicians Section)	RESOLVED, ~~that our American Medical Association study the potential feasibility of the creation of a hospital accreditation standard for implementation by the Centers for Medicare and Medicaid Services, through accreditation visits provided by The Joint Commission, Det Norske Veritas, and other accrediting agencies, such that hospital internal temperatures will require ongoing monitoring for compliance with a new standard for hospital internal temperatures~~ advocate for national standards/guidelines for maintaining building interior climates that minimizes the expenditure of energy to maintain a generally comfortable environment throughout the year (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that ~~hospital "common areas" must be maintained within a temperature range across which most humans would be comfortable when dressed for the weather of the season (for example, between 21 degrees C - 25 degrees C), toward decreasing health care's greenhouse gas impact, with a report back at the 2025 Interim Meeting of the AMA House of~~	Delegate instructed to amend as indicated.

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			~~Delegates~~ national standards/guidelines for building interior climate maintenance be developed that minimizes excesses of alterations of ambient temperature, yet be flexible enough to account for requirements of specialized interior environments, such as in hospitals, other treatment centers, and research facilities (Directive to Take Action); and be it further RESOLVED, that our AMA ~~will forward the results of this study regarding the maintaining of hospital internal temperatures within a suitably narrow range to health care journalists, hospital regulators, hospital executives, and other relevant parties, toward the eventual implementation of the findings and recommendations that are anticipated to be reached.~~ advocate for a strenuous national campaign to educate and encourage adherence to national standards/guidelines for building interior climate maintenance in the interest of enhancing population health via minimizing human contributions to global warming (Directive to Take Action)	
43	K	Res. 911 – Adequate Masking and HPV Education for Health Care Workers (Including Those Over Age 45) (Senior Physicians Section)	RESOLVED, that our American Medical Association advocate for the provision of N-95 masks or equivalent be required for all HCWs (health care workers) and patients who have potential exposure to HPV (Directive to Take Action) RESOLVED, that our AMA promote education for medical professionals on the importance of HPV education and professional responsibilities in these procedures (Directive to Take Action) RESOLVED, that our AMA work with the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP) and the Occupational Safety and Health Administration (OSHA) along with other relevant stakeholders to address airborne transmission risks of HPV during surgical procedures and to prevent health care-related transmission. (Directive to Take Action) RESOLVED, that our AMA Media Relations Team publicize with a press release to make physicians aware of these new policies, including those	Delegate instructed to support resolves 1-3, listen on resolve 4.

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			outlined in H-440.872, HPV Associated Cancer Prevention. (Directive to Take Action)	
44	K	Res. 914 – Protecting the Healthcare Supply Chain from the Impacts of Climate Change (Medical Student Section)	RESOLVED, that our American Medical Association support the development of strategies and technologies to strengthen supply chain networks, including building climate resiliency into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. (New HOD Policy)	Delegate instructed to listen, if extracted.
45	K	Res. 919 – Improving Rural Access to Comprehensive Cancer Care (American College of Obstetricians and Gynecologists)	RESOLVED, that our American Medical Association work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions (Directive to Take Action) RESOLVED, that our AMA call for increased federal and state funding to support research on rural cancer disparities in care, access, and outcomes and development of interventions to address those disparities (Directive to Take Action) RESOLVED, that our AMA advocate for evidence-based collaborative models for innovative telementoring/teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, treatment, and patient services in rural areas. (Directive to Take Action)	Delegate instructed to support and listen.

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

Item #	Ref Com	Title and sponsor(s)	Proposed policy
1	B	BOT Report 06 – Health Technology Accessibility for Aging Patients	RECOMMENDATIONS The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.: That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition. Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY (1) Our American Medical Association recognizes access to broadband internet as a social determinant of health. (2) Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations. (3) Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (4) Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities. (5) Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (6) Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and

Item #	Ref Com	Title and sponsor(s)	Proposed policy
			underserved populations. (7) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth. (8) Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (9) Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (10) Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details. (11) Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (Modify Current HOD Policy)
2	B	Res. 210 – Laser Surgery (American Academy of Ophthalmology)	RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners appropriately trained and currently licensed by the state to perform surgical services (Modify Current HOD Policy) RESOLVED, that our AMA amend policy H-475.980 Addressing Surgery Performed by Optometrists to read: 1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery." 2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)
3	B	Res. 223 – Mandated Economic Escalators in Insurance Contracts (New York)	RESOLVED, that our American Medical Association advocates through legislation or regulation for the mandatory insertion of an economic escalator provision in all commercial insurance contracts to account for economic inflation or a decline in Medicare Physician Fee Schedule (PFS). (Directive to Take Action)

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4	F	Res. 602 – Delaying the EFT Endorsement Timeline Revision for Section IOP Revisions (New England)	RESOLVED, that our American Medical Association House of Delegates candidate endorsement process revisions that were to be implemented for the 2026 election cycle be delayed to allow a thorough evaluation of unintended consequences and for revised State and Society bylaws and Section internal operating procedures to be duly ratified (Directive to Take Action) RESOLVED, that our AMA Board of Trustees expedite the approval of amendments to Section internal operating procedures as necessary to allow for their nomination and endorsement processes to align with impending changes to AMA House of Delegates procedure for nominations and endorsements. (Directive to Take Action)
5	J	Res 823 – Reigning in Medicare Advantage – Institutional Special Needs Plans (Louisiana)	RESOLVED, that our American Medical Association add I-SNPs to its advocacy efforts related to Medicare Advantage plans (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for increased policies, rules, and general oversight over I-30 SNPs (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)
6	K	Res. 930 – Economic Factors to Promote Reliability of Pharmaceutical Supply (Association for Clinical Oncology)	RESOLVED, that our American Medical Association amend H-100.956 “National Drug Shortages” by addition of a new Resolve: Our AMA support federal drug shortage prevention and mitigation programs that create payer incentives to enable practitioners and participating entities to voluntarily enter contracts directly with manufacturers that will pay more than prevailing market price for generic sterile injectable drugs at high risk of shortage to promote stable manufacturing and reliability of these products. (Modify Current HOD Policy)

END