

Highlights from the 2022 AMA Interim Meeting

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Catch up with the news and other key moments from the AMA House of Delegates' meeting in Honolulu. The 2022 AMA Interim Meeting concluded Nov. 15.

For a briefer rundown, check out this article: "ICYMI: 10 stories to read from the 2022 AMA Interim Meeting."

The meeting highlights below would not have been possible without writing and reporting by AMA Senior News Writers Sara Berg, Brendan Murphy and Andis Robeznieks, along with Contributing News Writers Tanya Albert Henry and Timothy M. Smith. Special thanks to Ted Grudzinski, AMA staff photographer, for his many great shots of the House of Delegates in action.

The delegates will next meet in June for the 2023 AMA Annual Meeting in Chicago. Find out more about AMA virtual and in-person events.

Thursday, Nov. 17

Patients deserve greater clarity on who is a physician—and who isn't

It's increasingly common for patients to encounter nonphysician practitioners as members of their health care teams. Meanwhile, ever more nonphysician practitioners have received advanced training resulting in a doctorate degree, such as the doctor of nursing practice.

To help patients keep pace with these changes, physicians should make new strides to clarify their roles and credentials vis-a-vis other members of the health care team and also promote collaboration among all health professionals, according to an AMA Council on Ethical and Judicial Affairs report that was adopted at the Interim Meeting.

The AMA *Code of Medical Ethics* touches on this issue in an opinion on collaborative care, which provides guidance on the roles of physicians in team-based settings where a mix of health professionals provide care.

Learn how the ethics code was updated regarding transparency in the context of team-based care involving nonphysician practitioners.

Also, find out how the AMA is leading the charge to stop inappropriate scope-of-practice expansions that threaten patient safety as part of the AMA Recovery Plan for America's Physicians.

AMA holds fast to principle: Reproductive care is health care

In its first time meeting since the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Care Organization* (PDF), the AMA House of Delegates adopted policies opposing the criminalization of pregnancy loss resulting from medically necessary care, supporting expanded access to abortion care and more.

"Since the *Dobbs* decision, health care in the United States has been thrown into chaos, with life-or-death decisions deferred to hospital lawyers, patients needing care driven across state lines, and uncertainty over the future of access to reproductive health care," said AMA President Jack Resneck Jr., MD.

"The AMA is steadfastly opposed to governmental interference in the practice of medicine, especially for well-established, medically necessary treatments," he added. "Patients and physicians need assurances that they won't be accused of crimes for medically necessary treatment. Unfortunately, this is the post-*Dobbs* world we now face. The fact that medically necessary treatment can be criminalized speaks volumes about these misguided abortion laws.

"Physicians and other health care professionals must attempt to comply with vague, restrictive, complex and conflicting state laws that interfere in the practice of medicine," Dr. Resneck noted. "These new policies will help the AMA to continue our advocacy and defend physicians in legislatures and the courts."

Learn how the AMA is working to protect patients and doctors from government interference and expand access to abortion care.

Wednesday, Nov. 16

Address private equity's growing impact on residency training

The role of private equity has increased markedly in recent years, and the consequences of that change are adversely affecting graduate medical education.

The 2019 closing of Philadelphia's Hahnemann University Hospital is one glaring example of the potential adverse consequences. The closure by a for-profit ownership temporarily left nearly 600 resident and fellow physicians without an accredited graduate medical education (GME) program to continue their training. From 2015 to 2019, the number of investor-owned, for-profit community hospitals in the U.S. rose 19% to more than 1,200 hospitals.

In an effort to address the potential pitfalls of private equity ownership of GME institutions, delegates adopted new policy to:

- Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity.
- Support publicly funded independent research on the impact that private equity has on graduate medical education.

"While positive developments have been made to implement protections for residents since the unexpected closure of Hahnemann, we are concerned that these changes are only temporary and may not lead to lasting change or prevent dramatic teaching hospital closures from happening again as a result of private equity investment," said AMA Immediate Past Chair Bobby Mukkamala, MD.

"We will continue to advocate for protections for residents who train in residency programs at private equity-owned teaching hospitals and encourage sponsoring institutions to monitor these programs to minimize disruptions to residency training—not only to ensure continuity of excellent education for physicians-in-training but also ensure they're able to continue providing much needed care for the communities and patients they serve," Dr. Mukkamala said.

"This is critically important for safety-net hospitals in underserved urban and rural areas that provide essential services to our most at-risk patients."

Read more about the AMA's newly adopted policy on the role of private equity in GME.

Expand pathway programs to help bright young students

Diversifying the medical profession is critical to improving care for all Americans. Connecting early with students from historically marginalized racial and ethnic groups, even as early as middle school,

can yield results when it comes to creating a physician workforce that is more representative of the U.S. patient population, according to a resolution presented by the Illinois delegation.

Pathway programs have proven valuable in providing comprehensive educational support and enrichment that levels the opportunities for participants to earn admission to medical school. The results include improved test scores and better graduation and college matriculation rates.

When those programs connect medical and high-school students in a culturally relevant manner, they offer potential to help students from historically marginalized racial and ethnic groups with identity formation and perceived achievement goals, the resolution says.

Considering the value these programs can offer in reshaping the makeup of America's physician workforce, delegates adopted new policy to:

- Urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
- Encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
- Recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
- Encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
- Consider quality of K–12 education a social determinant of health, and thus advocate for implementation of Policy H-350.979 encouraging state and local governments to make quality elementary and secondary education available to all.

Doctors eye illegal sources, better data to address firearm deaths

To help reorient the public and national conversation about the national firearm injury public health crisis, the House of Delegates adopted new policy to “support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.”

Delegates also directed the AMA to:

- Work with key stakeholders—including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victim advocacy groups, health care providers, and state and federal government agencies—to develop evidence-informed public health recommendations to mitigate the effects of violence

committed with firearms.

- Collaborate with key stakeholders and advocate for national public forums—including, but not limited to, online venues, national radio and televised or streamed in-person town halls—that bring together key stakeholders and members of the general public to focus on finding common ground, nonpartisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Learn about other actions taken by delegates to prevent firearm injuries and deaths, including among older adults.

Change resident-selection process to boost equity

The odds of membership in one of the most prominent medical honors societies are six times greater for white medical students than Black medical students and those honors remain a factor in the physician residency-selection process. The lack of racial, ethnic, socioeconomic and geographic diversity in physician residency and fellowship selection was addressed in new policy adopted at the Interim Meeting.

Delegates adopted new policy to:

- Encourage medical schools, medical honor societies, and residency and fellowship programs to work toward ethical, equitable and transparent recruiting processes, which are made available to all applicants.
- Advocate and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the AMA Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency-and-fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service by program directors on the diversity of entrants into residency.
- Encourage caution among medical schools and residency/fellowship programs when using novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

Read about the additional AMA policy changes aimed at boosting equity in the resident-selection process.

AMA backs stronger leave policies for medical students, doctors

Physicians not only care for patients but are also caregivers for family members. For physicians to stay focused on their patients, they also need to have support to care for their own families. In recent years, leave policies for medical students, residents and fellows have been more supportive of time to give birth, rear an infant and care for infirm family members while training.

“It is important that medical students and all physicians-in-training have access to equitable, adequate and paid parental, family and medical necessity leave to support their health and well-being,” said AMA Immediate Past Chair Bobby Mukkamala, MD.

The House of Delegates modified existing policy to encourage implementation of parental, family and medical necessity leave for medical students and physicians. The updated policies call on the AMA to:

- Study the impact on and feasibility of medical schools, residency programs, specialty boards and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
- Recommend 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.

Read about the AMA's other actions to boost medical and family leave for medical students, residents, fellows and physicians in practice.

No matter the patient’s skin color, pulse oximetry should work

Research published last year in *JAMA Network Open* found an increased incidence of hidden hypoxemia in Black, Hispanic and Asian patients. This has been linked to a rise in major organ dysfunction at 24 hours in otherwise matched groups and in-hospital mortality, notes a resolution that was presented by Washington State Medical Association.

JAMA Internal Medicine also has reported greater occult hypoxemia in Asian, Black and Hispanic patients with COVID-19. This “was associated with significantly delayed or unrecognized eligibility for COVID-19 therapies,” says the resolution, which notes that concerns about skin pigmentation-based pulse oximetry inaccuracies have existed for decades.

Additionally, the Food and Drug Administration (FDA) acknowledged that skin pigmentation can affect the accuracy of pulse-oximetry readings.

Delegates directed the AMA to make recommendations to the FDA “that will ensure health care personnel and the public are educated on the limitations of pulse-oximeter technology so they can

account for measurement error.”

Earlier this month, AMA President-elect Jesse M. Ehrenfeld, MD, MPH, addressed this topic while participating in a meeting with the agency.

“Concerns about the accuracy of pulse oximeters in pigmented skin have been noted for more than 30 years, yet Black and Brown communities are still facing adverse health impacts from these devices—particularly during the COVID-19 pandemic when use of and reliance on pulse oximeters increased,” Dr. Ehrenfeld said in a statement after the House of Delegates’ action.

“We urge the FDA to take swift action to address the growing uncertainty around these devices, including making sure health care professionals are aware of their limitations and increase testing of devices that were already cleared by the agency, to ensure the health and safety of the public,” said Dr. Ehrenfeld, an anesthesiologist in Wisconsin.

Don’t put kids behind bars, says the AMA

Twenty-seven states have no minimum age of juvenile adjudication. In recognition of that reality, delegates took action to establish such an age floor in the U.S., where proportionally more children interface with the juvenile justice system than in any other country.

“Research shows that people who experience their first incarceration as a young child have worse health outcomes as adults compared with those first incarcerated as adolescents,” said AMA Trustee Drayton Charles Harvey, a California MD-PhD student. “We believe setting a minimum age for when a young person enters the juvenile justice system will lessen the harmful effects that early justice involvement can have on children and their families over the course of their lives recognizing that children and adolescents need developmentally appropriate, trauma-informed care and services.”

While research by the National Governors Association has identified 15 states that have set the minimum age at 10 for juvenile adjudication, delegates adopted policy to “establish minimal age of 14 years for juvenile justice jurisdiction in the United States.” That aligns with the United Nations’ recommendation to boost the minimum juvenile jurisdiction age from 12 to 14.

Learn about other actions the AMA is taking to reduce incarceration's public health burden.

Study pros and cons of virtual residency interviews

The pandemic changed the course of the residency interview process, with many programs moving to a virtual format that drastically cut travel expenses for applicants.

Prior to graduate medical education (GME) interviews going virtual, medical students were spending as much as \$11,000 on travel, with a typical student spending \$4,000. Studies have indicated that both applicants and residency program directors believe that a virtual interview format should replace the traditional in-person one, according to a resolution presented by the AMA Medical Student Section.

About 60% of residency program directors surveyed said they planned to use virtual platforms for residency interviews in the future, according to the resolution.

Both the positive attitudes about the format and the cost-reduction aspects of virtual interviews align with AMA goals to increase residency interview efficiency and control costs for students. However, there are concerns that students who choose a virtual interview may be disadvantaged compared to applicants who have an in-person interview.

To ensure a fair assessment for all applicants, delegates adopted new policy calling on the AMA to:

- Work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long-term success, and well-being of students and residents.
- Encourage appropriate stakeholders—such as the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Intealth and the Accreditation Council for GME—to study the feasibility and utility of videoconferencing for GME interviews, and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews to guide the development of equitable protocols for expansion of hybrid GME interviews.

What is physicians' duty to treat during pandemics?

The notion that physicians have a professional duty to treat during infectious disease outbreaks has waxed and waned historically. And while questions around the interpretation of this duty have often seemed hypothetical or remote, they became very real and immediate during the COVID-19 pandemic.

Since its inaugural edition, the *AMA Code of Medical Ethics* has codified expectations that physicians would accept risk, including in a current opinion on physician responsibility in disaster response and preparedness, which provides guidance on evaluating the risks of providing care to individual patients vis-à-vis the need to be available to provide care in the future.

The *Code* clarifies that this obligation isn't absolute, however, noting that "physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future."

COVID-19 has certainly renewed questions around limits to professional duty. Learn how the AMA is updating the *Code of Medical Ethics* to advise physicians.

Tuesday, Nov. 15

Don't ask Native American future doctors about blood quantum

Of the racial groups defined in the U.S. census, American Indians and Alaska Natives is the only one whose identity is associated with fractions of blood, and this introduces significant potential for discrimination.

The Association of Native American Medical Students has received reports of residency-program interviewers asking American Indian and Alaska Native applicants inappropriate questions about blood quantum, according to an AMA Medical Student Section resolution presented at the meeting.

The mathematical blood quantum—the amount of "native blood" in a person's ancestry—was implemented by the federal government requiring the Bureau of Indian Affairs to issue a Certificate Degree of Indian Blood as evidence of Native American ancestry. Blood quantum has been a topic of controversy as a relic of government policy that continues to marginalize these populations.

"Questioning American Indian and Alaskan Natives about their blood quantum is a barrier for applicants pursuing medical education, further exacerbating the shortage of American Indian medical trainees," says AMA Trustee Madelyn E. Butler, MD. "Our AMA supports the creation of culturally safe interview environments to reduce racial biases and advocates for the inclusion of American Indians and Alaskan Natives in established medical training programs."

To create a culturally safe interview environment and reduce racial biases, delegates directed the AMA to "work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, the Association of American Medical Colleges and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency and fellowship application process."

AMA: U.S. health sector should decarbonize

Climate change represents a significant public health threat and harms individual patients, driving up rates of allergies, asthma, and respiratory and cardiovascular disease—and it is time for policymakers and health care organizations to act accordingly, says an AMA Council on Science and Public Health report whose recommendations were adopted at the Interim Meeting.

“Scientific evidence continues to show the significant public health threat that climate change represents. Physicians are already seeing firsthand the adverse impact of climate change on the health of their patients,” said AMA Trustee Drayton Charles Harvey. He is a dual-degree MD-PhD candidate at the University of Southern California Keck School of Medicine and the California Institute of Technology.

“This is an existential threat. We must continue to do everything we can to combat the climate crisis and act now to prevent catastrophic levels of global warming,” Harvey added. “Physicians pledge to do no harm, and now it is time for the health sector to do the same by joining forces to commit to decarbonization and public health.”

Having declared climate change a public health crisis in June, delegates added to existing policy a goal to “reduce U.S. greenhouse gas emissions aimed at a 50% reduction in emissions by 2030” with existing policy calling for carbon neutrality by 2050.

Learn about the other actions the AMA is taking to reduce health care's environmental impact.

Physicians oppose mandatory gender-based treatments for athletes

Efforts by the athletic community to regulate the participation of transgender athletes and athletes with differences in sexual development go back decades. But for all their variations—from parading athletes naked before panels of judges to the use of sex chromatin tests—these efforts have been largely incompatible with international human rights norms and standards, according to an AMA Board of Trustees report that was adopted at the Interim Meeting.

“The AMA opposes athletic eligibility regulations that contribute to discrimination and stigma attached to naturally occurring differences in gender and sexual identity, sexual development and orientation,” said AMA Trustee David H. Aizuss, MD. “Unnecessary medical interventions to change natural hormone variations as a prerequisite for athletic competition must not be forced on physicians to artificially alter the natural ability of transgender athletes and athletes with differences in sexual development.”

Learn more about the AMA's newly adopted policy on the physician's role in complying with these unnecessary regulations.

Harm-reduction efforts needed to curb overdose epidemic

The U.S. drug-overdose epidemic continues to worsen as the number of deaths grew by nearly 15% in 2021—a grim total fueled by a 23% rise in the number of deaths linked to illicitly manufactured fentanyl—highlighting a need to encourage harm-reduction measures.

To address the problem, delegates modified existing AMA policy to:

- Encourage state and county medical societies to advocate for harm-reduction policies that provide civil and criminal immunity for the possession, distribution and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug-contamination testing and injection-drug preparation, use and disposal supplies.
- Support efforts to increase access to fentanyl test strips and other drug-checking supplies for the purpose of harm reduction.

“The AMA has strongly supported increased use of a broad array of harm-reduction efforts to reduce death and other harms from nonmedical use of drugs, including for people who inject drugs,” said AMA Trustee Thomas J. Madejski, MD. “These efforts include greater access to naloxone, syringe services programs and pilot programs for overdose prevention sites/supervised injection-use facilities. Fentanyl strips are part of this effort, and we urge states to take steps to help a vulnerable population.”

Learn more about this and the AMA's support for using opioid-litigation settlement funds to boost physician training on the treatment of opioid-use disorders.

AMA: The hour has come to sunset daylight saving time

The House of Delegates has moved to support ending daylight saving time (DST) and shift permanently to standard time. The American Academy of Sleep Medicine and others pointed to the potential health benefits of the switch.

“For far too long, we’ve changed our clocks in pursuit of daylight, while incurring public health and safety risks in the process. Committing to standard time has health benefits and allows us to end the biannual tug of war between our biological and alarm clocks,” said AMA Trustee Alexander Ding, MD, MA, MBA, a diagnostic and interventional radiologist.

Sleep experts say that standard time, which shifts daylight hours earlier in the morning, aligns best with human circadian biology. The sudden change from standard time to DST in March is linked to significant public health and safety risks, including higher risk of adverse cardiovascular events, mood disorders and car crashes. Some studies suggest that the body clock does not adjust to DST even after a few months.

This year, the U.S. Senate passed a bill to establish permanent DST, but there is a lot of daylight between that version and the AMA-endorsed approach. The House has not taken up a bill on the issue. Twenty states have endorsed year-round DST, but Congress must act for the changes to take effect.

“Eliminating the time changes in March and November would be a welcome change. But research shows permanent daylight saving time overlooks potential health risks that can be avoided by establishing permanent standard time instead,” Dr. Ding said. “Sleep experts are alarmed. Issues other than patient health are driving this debate. It’s time that we wake up to the health implications of clock setting.”

Read more about why sleep-medicine experts recommend using standard time 365 days a year.

Subject third-party Rx benefit administrators to PBM rules

Third-party administrators (TPAs) managing specialty pharmacy benefits are negatively affecting patients and the practice of medicine nationwide, according to a resolution presented by 17 national specialty and state medical societies.

TPAs are similar to pharmacy benefit managers (PBMs) in that they manage formularies, negotiate rebates, process claims and pay pharmacies for prescriptions. Because TPAs are relatively new to the health care landscape, they are not bound to PBM-related regulations and laws. With little transparency and opaque practices, third-party benefit administrators managing specialty pharmacy benefits use heavy-handed tactics with patients and physicians to force them to use preferred prescriptions and generally use proprietary algorithms to guide decision-making, says the resolution that was introduced.

“Given that TPA services can have a negative impact on access and affordability for specialty drugs, the AMA will remind state and federal regulators not to ignore TPAs in their oversight of drug middlemen,” said AMA Trustee Marilyn Heine, MD. “Specialty drugs are often a critical part of a patient’s care for cancer, certain forms of arthritis and other medical conditions. As such, the AMA believes TPAs should be subject to the same licensing, registration and transparency-reporting requirements that regulators mandate for PBMs.”

To address this new market presence, the House of Delegates adopted policy recommending “that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing PBM regulatory frameworks and statutes and be subject to the same licensing, registration and transparency reporting requirements.”

The AMA also will “advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels.”

Make it easy to compare Medicare Advantage plans on the web

Older adults trying to determine whether a Medicare Advantage plan makes sense for them—and which of the options are best for their needs—often face confusion and a lack of clarity in exactly what each plan offers, according to a resolution presented by the AMA Senior Physicians Section.

Medicare Advantage plans must provide enrollees with additional benefits beyond the ones that Medicare covers, in addition to coverage of all services that Medicare Parts A and B cover. But when Medicare supplement plans cannot be used in Medicare Advantage, patients must make co-payments themselves and these plans often use prior authorization and deny claims that would be paid in regular Medicare.

To promote uniformity and enforcement of Medicare Advantage plans and regulation and to help older adults more easily determine the differences between plans, the AMA will advocate:

- Better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine whether those standards are being met for physicians and their patients.
- That Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the U.S. on their website, along with the additional benefits provided.
- That CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

“Patients rely on directories of in-network physicians to make informed comparisons of Medicare plans or choose a physician,” said AMA Trustee Scott Ferguson, MD. “But patients face a false appearance of choice when Medicare Advantage plans create networks that are too thin and directories that are too flawed. A comprehensive and authoritative source of accurate information is needed from federal authorities to support patients in Medicare Advantage.”

Require mental health parity in Medicare

Medicare is the single largest payer not subject to laws mandating parity in coverage for mental health and substance-use disorder (SUD) and the benefits for the treatment of other medical conditions, and

its coverage gaps, limitations and restrictions on those services result in a denial of the full continuum of mental health and SUD benefits available to Medicare beneficiaries, says a resolution introduced at the Interim Meeting.

Nearly 2 million Medicare beneficiaries report having a substance-use disorder, yet only 11% got any SUD treatment last year, according to research cited by the psychiatric organizations that presented a resolution aiming to address the issue.

Delegates did so by amending existing policy to support:

- Parity of coverage for mental health and substance-use disorders.
- Federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare parts A, B, C and D.
- Requiring Medicare parts A, B, C and D to cover all levels of mental health and substance-use disorder care, consistent with nationally recognized medical professional organization level-of-care criteria for mental health or SUDs.
- Require all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws.

Work to close insurance coverage gaps for preventive care

Across the U.S. population, gaps in health insurance coverage result in people missing opportunities to achieve optimal health status.

Delegates took steps to address three such gaps at the Interim Meeting to help protect and expand coverage for vaccines under Medicare, PrEP for HIV, and treatments for adult and pediatric obesity.

Learn more about the AMA's most recent steps to expand insurance coverage.

Monday, Nov. 14

Preventing deadly gun violence will be focus of AMA task force

Having declared gun violence a public health crisis, America's physicians have grown increasingly frustrated at the nation's failure to make progress in preventing gun-related deaths and injuries. Already this year, more than 30,000 have died of gun violence in the U.S.

At the Interim Meeting, the House of Delegates took action to explore new avenues to address this public health crisis, including a task force focus on gun-violence prevention and violence-interruption programs.

“Six years ago, just before the AMA Annual Meeting, a shooting at the Pulse nightclub in Orlando prompted physician and medical student delegates to declare firearm violence a public health crisis in the United States,” said AMA President Jack Resneck Jr., MD. “Today we gather in the wake of another tragic shooting—this one on the campus of the University of Virginia—that left young people dead and a campus on lockdown.

“We cannot continue to live this way,” said Dr. Resneck. “Our children spend portions of school days running active-shooter drills, knowing full well their classroom could be next. In movie theaters, houses of worship, hospitals, big cities and small towns, firearm violence has shattered any sense of security and taken lives. As physicians and healers, we are committed to ending firearm violence by advocating for common-sense, evidence-based solutions, and this task force will be key to that ongoing effort.”

Learn about the AMA’s next steps to boost evidence-based approaches to preventing firearms violence.

What’s at stake in AMA advocacy

This morning, delegates have the opportunity to attend the AMA Council on Legislation Executive Committee’s Open Forum (9–10:30 a.m. HST, Room 312) to learn how the AMA is working to protect patients and physicians through its federal and state advocacy efforts. The forum also gives delegates the chance share with the council and others in the room their comments on emerging legislative and regulatory issues affecting patients and the practice of medicine.

The AMA is your powerful ally in patient care as an influential voice at the state and federal level that informs, guides and generates support for policies that advance meaningful health care initiatives. Learn from a new section on the AMA’s website—Advocacy in Action—about what’s at stake and what the AMA is doing to address the concerns most relevant to patients and physicians.

The AMA is actively working for America’s physicians on a broad range of issues. Learn about the full breadth of the AMA’s advocacy efforts, and explore further the AMA Recovery Plan for America’s Physicians.

Sunday, Nov. 13

Education sessions this afternoon

Among the offerings available to delegates in Honolulu are those below (all times HST):

- **2:30–3:30 p.m.** “Addressing Misinformation and Misconceptions: Caring for Patients with Persistent Symptoms Attributed to Lyme Disease.” Room 317 B.
- **2:30–4 p.m.** AMA Council on Ethical and Judicial Affairs Open Forum: “Finding Opportunities to Promote Equity in Health Care.” Room 318 B.
- **2:30–4 p.m.** “Workplace Violence in Healthcare Settings.” Room 318 A.
- **2:30–4:30 p.m.** Litigation Center Open Meeting. Room 317 A.
- **3–4 p.m.** “PASC/Long COVID Syndrome: 2022 Update.” Room 319 A.

Reference committees meet today

AMA delegates will offer testimony today on more than 100 reports and resolutions up for consideration at the meeting. Delegates draw on their expertise, the best evidence in the medical and health policy literature, and the insights of their state medical associations and national medical specialty societies to weigh in on proposals that run the gamut of issues affecting patients and physicians.

These reference committees will meet from 8:30 a.m.–1:30 p.m. HST today:

- Reference Committee on Amendments to Constitution & Bylaws, which covers the **AMA constitution, bylaws and medical ethics matters**. Room 313 A–C.
- Reference Committee B, which covers **legislation**. Kamehameha III.
- Reference Committee C, which covers **medical education**. Room 311.
- Reference Committee F, which covers **AMA governance and finance**. Kalakua Ballroom.
- Reference Committee J, which covers **medical service, practice and insurance**. Room 316 A–C.
- Reference Committee K, which covers **science and public health**. Room 323 A–C.

Watch this short video below, from 2019, or explore this AMA Ed Hub™ interactive course to learn how AMA policy is made.

Saturday, Nov. 12

AMA CEO: Focused plan has produced 10 years of results

Dr. Madara reflected on the AMA's 175th anniversary earlier this year during his address at the 2022 AMA Annual Meeting in Chicago. In Honolulu, he remarked on another milestone: the 10-year anniversary of the AMA's long-term strategic plan.

The plan was developed with two main goals in mind—that the actions of the AMA more strongly reflect the organization's mission, and that those actions have a strong, positive impact.

This led to a three-pronged strategy aimed at confronting chronic disease, driving professional development and removing obstacles that interfere with patient care.

Read more from Dr. Madara about how the AMA's work today is helping move medicine forward for the 21st century.

Physicians must be empowered to put patients first: AMA president

Whether fighting to stop Medicare pay cuts, fix prior authorization or reduce administrative burdens that lead to burnout, the AMA has physicians' backs. And when it comes to advancing health equity and protecting patients' access to evidence-based reproductive health care, gender-affirming services and reliable scientific facts, the AMA won't back down.

"You know and I know that we did not pick these fights, and that our organization isn't on any political team," said AMA President Jack Resneck Jr., MD, during his speech at the opening session of the AMA Interim Meeting in Honolulu.

With all the pressures that physicians face, it's not surprising that burnout rates are soaring—going from 38% to 63% in 2021, with one in five physicians saying that they will leave the profession in the next two years.

“We haven’t lost the will to do our jobs. We are frustrated that our health care system is putting too many obstacles in our way,” Dr. Resneck said.

Telling physicians “to be more resilient, do a little more yoga, and to enjoy a free dinner from the hospital CEO isn’t going to heal the burnout. While wellness has its place, to focus solely on resilience is to blame the victim,” the AMA’s president said.

“We need to fix what’s broken—and it’s not the doctor,” he said to big applause from delegates.

Learn more from Dr. Resneck about how the AMA is fighting on behalf of America's patients and physicians.

Health equity open forum this afternoon

After today’s opening session of the AMA House of Delegates, there will be a two-session open forum hosted by the AMA Center for Health Equity.

The first session will provide a brief overview of Rise to Health: A National Coalition for Equity in Health Care, in which delegates will learn about key strategies and concrete actions professional societies and individual physicians can take to advance health equity.

In the second session, members of the inaugural cohort of the Medical Justice in Advocacy Fellowship will present their culminating projects, which encompass physician-led advocacy to advance health equity. Through rotating small-group discussions, participants will explore these projects and identify opportunities to replicate physician-led advocacy in their own settings. (2:30–5 p.m. HST, Kalakua Ballroom).

Learn more about claiming CME for Interim Meeting education sessions.

Friday, Nov. 11

6 issues to watch at the 2022 AMA Interim Meeting

Nearly 700 physicians and medical students are gathering in Honolulu for the 2022 AMA Interim Meeting to consider proposals across a wide range of clinical practice, payment, medical education and public health topics. The meeting's opening session is Saturday and the meeting runs through Nov. 15.

Among the notable issues that will be addressed are these:

- Addressing the impact of private equity on medical training.
- Advocating reduced greenhouse gas-emissions to protect public health.
- Designating opioid settlement money to train more addiction-treatment physicians.
- Ensuring accuracy of pulse-oximeter readings in patients with pigmented skin.
- Opposing athletic-eligibility policies that mandate clinically unnecessary medical interventions.
- Removing measures of Native ancestry in medical school applications.

Learn more.

Quick links for the meeting

These essentials will help you get the most out of the meeting.

- Access the reports and resolutions delegates will consider, as well as reference committee reports and final actions as they become available.
 - Search the AMA Pictorial Directory to find your peers and stay connected before, during and after Annual and Interim Meetings (AMA members only).
 - Find instructions on downloading and accessing the meeting app.
 - Learn about the education sessions offered and how to claim CME.
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Follow the meeting on social media

Highlights of the meeting's key moments and House of Delegates policy actions will be posted daily. Also visit the 2022 AMA Interim Meeting website, and the AMA's Facebook page, Instagram and Twitter account using #AMAmtg.

Addresses from leadership and more will be featured on the AMA's YouTube channel. After the meeting, be sure to follow the AMA on LinkedIn for additional updates as well.