REPORT OF THE SPEAKERS

Speakers’ Report 1-I-17

Subject: Recommendations for Policy Reconciliation

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Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” states in relevant part that the Speakers should “present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete.”

Your Speakers present this report, the second of 2017, to deal with policies that were affected by actions taken at this past June’s Annual Meeting.

Suggestions on other policy statements that are thought to be outdated or needing revision for any other reason should be sent to hod@ama-assn.org. That address may also be used to contact your Speakers on any House-related matter.

RECOMMENDED RECONCILIATIONS

References to completed directives to be deleted from policy statements

The following changes will delete references to reports that have been completed but otherwise do not affect existing policy.

1. Policy D-405.988, “The Preservation of the Private Practice of Medicine,” includes a reference to a report that was considered by the House at the 2015 Annual Meeting as Board of Trustees Report 16. That reference will be stricken, but the remainder of the policy unchanged.

Policy D-405.988, “The Preservation of the Private Practice of Medicine”
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice, with a progress report at the 2015 Annual Meeting; and (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency

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programs to present physicians in training with information regarding private practice as a viable option.

2. Policy G-600.035, “The Demographics of the House of Delegates” includes a directive that has been accomplished. The Council on Long Range Planning and Development provided the requested information in Report 2-A-17. Having been completed, the directive will be dropped.

Policy G-600.035, “The Demographics of the House of Delegates”

1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. 2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. 3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations.

4. Our AMA will convene a group of stakeholders at a forum in conjunction with the 2016 Annual Meeting to identify viable solutions with which to promote diversity, particularly by age, of state and specialty society delegations, with a summary of the findings to be included in the next CLRPD report on the demographic characteristics of the House of Delegates.

3. H-110.987, “Pharmaceutical Cost,” calls for a progress report on a “drug pricing advocacy campaign at the 2016 Interim Meeting.” That report was delivered in Board of Trustees Report 10, AMA Initiatives on Pharmaceutical Costs. Hence the specific call for the report will be removed from policy.

H-110.987, “Pharmaceutical Cost”

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting.
Five policies should be rescinded in full because they have been superseded by newer policies and, where necessary, bylaws amendments. Three policies deal with specialty society representation, a process that has been completely revised over the last year. Two other policy statements are directives dealing with the Council on Ethical and Judicial Affairs; both have been accomplished and should be rescinded.

4. Two policies deal with the now abandoned balloting system used for apportioning delegates to specialty societies. In light of amendments to the bylaws and Policy G-600.027 at the 2017 Annual Meeting, these older policies should be rescinded. The first is Policy G-600.023, “Designation of Specialty Societies for Representation in the House of Delegates,” which was adopted at the 2013 Interim Meeting. Although the final paragraph of the policy has some merit, your Speakers believe that it is incumbent on them to monitor the delegate allocation process and no explicit requirement is needed. Moreover, in the event of a perceived problem, any delegate may propose a resolution to address the matter. As such, the policy as a whole is no longer viable and will be rescinded.

Policy G-600.023, “Designation of Specialty Societies for Representation in the House of Delegates”

1. Specialty society delegate allocation in the House of Delegates shall be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof. 2. Specialty society membership data shall be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates. 3. The current specialty delegation allocation system (ballot and formula) will be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates. 4. This system shall be tested with all specialty societies with more than one delegate seated in the House of Delegates. 5. Organizations that would lose or gain one or more delegates through this pilot delegate allocation system shall assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting. 6. In the future, any system of delegate allocation will continue to be monitored and evaluated for improvements.

5. Likewise, Policy G-600.021, “Specialty Society Representation in our AMA House,” which dates from 1996 and was altered in 2012, will be rescinded.

Policy G-600.021, “Specialty Society Representation in our AMA House”

The number of AMA delegate positions allocated to the specialty societies in our AMA/Federation House will be determined in the following manner: (1) The number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1000 AMA members, or portion of 1000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to our AMA; and (2) Each specialty society that meets the eligibility criteria and is represented in our AMA/Federation House will be assured of at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA. (3) Our AMA will: (a) continue to include the ballot postcard in the Member Welcome Kit; (b) continue to promote the online ballot application to
increase specialty society designations; (c) work with all willing specialty societies to solicit additional specialty society designations, using both printed ballots and electronic communications vehicles; and (d) continue to send email ballot solicitations to members who have not yet cast a ballot. (4) The current ballot system will remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

6. Policy G-600.135, “Specialty Society Delegate Representation in the House of Delegates,” will be rescinded as it has been superseded by the new procedure to apportion specialty society delegates that will be implemented in 2018.


1. Our AMA will continue efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation. 2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will: (a) establish annual targets for the overall proportion of AMA members from whom designations should have been received; (b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations; (c) limit the number of delegates a society can acquire to the number that would be obtained if all the society’s AMA members designated it for representation; (d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and (e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally. 3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports: (a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and (b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion. 4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates. 5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. 6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

7. The multi-year effort by the Council on Ethical and Judicial Affairs to modernize the Code of Medical Ethics culminated with the adoption of CEJA Report 2-A-16. At that same meeting, and partly because of the lengthy and somewhat tortuous effort to achieve consensus on the
Code, the House also adopted Policy D-600.957 calling for an evaluation of the deliberative processes surrounding CEJA reports. The initial response to that policy came in CEJA Report 3-I-16, which was referred because important underlying issues of the relationship between the Council and the HOD required further study. At the 2017 Annual Meeting, the Board of Trustees submitted Report 19, providing the requested evaluation and establishing Policy G-600.009, “CEJA and House of Delegates Collaboration.” Given the Board’s report, the following policy has been accomplished and will be rescinded.

D-600.957, “CEJA and House of Delegates Deliberation”
1. Our AMA will evaluate how the collaborative process between the House of Delegates and the Council on Ethical and Judicial Affairs can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy and report back at the 2016 Interim Meeting. 2. Our AMA will evaluate how a periodic review of Code of Medical Ethics guidelines and reports can best be implemented, and report back.

Policy D-478.969, “Social Media Trends and the Medical Profession,” asked that CEJA examine how physicians may ethically use social media for educational and advocacy purposes. CEJA submitted Report 2 at this past June’s meeting, which included a section dealing specifically with uses of social media for education or advocacy. The policy will be rescinded as having been completed.

D-478.969, “Social Media Trends and the Medical Profession”
Our AMA will ask the Council on Ethical and Judicial Affairs to reconsider AMA Ethical Opinion E-9.124, Professionalism in the Use of Social Media.

Policies to be modified

The most recent policy dealing with the apportionment of specialty society delegates requires relatively minor modifications to bring it up to date.

G-600.027, “Designation of Specialty Societies for Representation in the House of Delegates,” was modified at 2017 Annual Meeting to clarify the formula that will be used to apportion delegates to specialty societies in the House of Delegates. The policy will be modified to delete a call to study bylaws changes necessitated by the policy change and the date of the initiation of the policy as those elements are no longer relevant.

1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.

2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process:
   (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof.
      (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the
subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

(b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies.

(i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

(ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

(iii) In the case of a tie, the previous year’s data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.

3. The Council on Constitution and Bylaws will investigate the need to change any policy or bylaws needed to implement a new system to apportion national medical specialty society delegates.

4. This new specialty society delegate apportionment process will be implemented at the first Annual Meeting of the House of Delegates following the necessary bylaws revisions.

5. Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

The policy below requires a slight change to use the preferred language consistently. The change is presented here in the interest of transparency. The original sponsor favors the change.

10. In June the House adopted policy supporting the use of “person-first” language in addressing the needs of patients affected by obesity, which is catalogued as Policy H-440.821, “Person-First Language for Obesity.” The language in the third paragraph is slightly inconsistent as adopted and will be changed from “patient-first” to “person-first.”

Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of patient person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.

Fiscal note: $250 to edit policy database.