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Subject: Annual Report

Presented by: Jack Resneck, Jr. MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

The Consolidated Financial Statements for the years ended December 31, 2018 and 2017 and the Independent Auditor’s report have been included in a separate booklet, titled “2018 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-A-19

Subject: AMA 2020 Dues

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
             (Greg Tarasidis, MD, Chair)

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA’s membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2020 Membership Year

The Board of Trustees recommends no change to the dues levels for 2020, that the following be adopted and that the remainder of this report be filed:

<table>
<thead>
<tr>
<th>Membership Category</th>
<th>Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Members</td>
<td>$420</td>
</tr>
<tr>
<td>Physicians in Their Second Year of Practice</td>
<td>$315</td>
</tr>
<tr>
<td>Physicians in Military Service</td>
<td>$280</td>
</tr>
<tr>
<td>Physicians in Their First Year of Practice</td>
<td>$210</td>
</tr>
<tr>
<td>Semi-Retired Physicians</td>
<td>$210</td>
</tr>
<tr>
<td>Fully Retired Physicians</td>
<td>$84</td>
</tr>
<tr>
<td>Physicians in Residency Training</td>
<td>$45</td>
</tr>
<tr>
<td>Medical Students</td>
<td>$20</td>
</tr>
</tbody>
</table>

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-19

Subject: Conduct at AMA Meetings and Events

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-140.954, “Harassment Issues Within the AMA,” which provided:

That our American Medical Association immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or both with report back regarding said processes and implementation at the 2019 Annual Meeting. (Directive to Take Action)

In furtherance of Policy D-140.954, the AMA immediately engaged two outside consultants, Amy L. Bess, Esq. of Vedder Price PC and Sherry Marts of S*Marts Consulting, to review, evaluate and provide recommendations as to the AMA Policy H-140.837, “Anti-Harassment Policy,” including the investigative and disciplinary processes thereunder, as previously adopted by the House of Delegates (see Appendix A for the consultants’ professional biographies). This report of the Board of Trustees summarizes the evaluation and joint recommendations provided by the consultants and recommends revisions to the procedures implementing the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities. The Board of Trustees believes that these recommendations will result in significant improvements to help ensure that AMA meetings are safe, welcoming and free of inappropriate conduct.

BACKGROUND

At the 2017 Annual Meeting, the AMA House of Delegates adopted Policy H-140.837, “Anti-Harassment Policy.” The policy communicates the AMA’s commitment to zero tolerance for harassing conduct at or in conjunction with AMA-sponsored meetings and events, and provides a clear definition of what constitutes harassing conduct (see Appendix B for full text). The policy was proffered by Board of Trustees Report 23-A-17, which provided that:

Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.
At the 2018 Annual Meeting, the Board of Trustees presented Board of Trustees Report 20-A-18, which recommended procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards. Such recommended procedures included:

- Mechanisms by which any persons who believe they have experienced or witnessed conduct in the AMA House of Delegates or in other meetings and activities hosted by the AMA (e.g., meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards) in violation of Anti-Harassment Policy H-140.837 could promptly notify the presiding officer(s) of such AMA meeting or activity, the Chair of the Board and/or the AMA Office of General Counsel, or report such violation by means of a telephonic or online hotline (with the option to report anonymously).
- Prompt and thorough investigation of harassment complaints to be conducted by AMA Human Resources, with AMA Human Resources responsible for making determinations as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.
- The establishment of a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA and the President-Elect of the AMA, to which violations of Anti-Harassment Policy H-140.837 would be referred for disciplinary and/or corrective action, including but not limited to expulsion from the relevant AMA meetings or activities and/or referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.

At the 2018 Annual Meeting, following extensive testimony concerning the recommended procedures set forth in Board of Trustees Report 20-A-18, the AMA House of Delegates adopted with amendment the recommendations of the Board of Trustees as to disciplinary action. In particular, the House of Delegates modified the recommendations of the Board of Trustees whereby all violations of Anti-Harassment Policy H-140.837 would be referred immediately to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary action, rather than to the three-member disciplinary committee recommended by the Board of Trustees, as follows:

If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA -associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

At the 2018 Interim Meeting, CEJA presented Council on Ethical and Judicial Affairs Report 4-I-18, “CEJA Role in Implementing H-140.937, ‘Anti-Harassment Policy,’” expressing concerns about the scope of responsibilities delegated to CEJA under Anti-Harassment Policy H-140.837(3),
Disciplinary Action, as modified and adopted by the House of Delegates at the 2018 Annual Meeting, and requesting that Policy H-140.837(3), Disciplinary Action, be reconsidered. The House of Delegates did not accept CEJA’s recommendation, but did adopt Policy D-140.954, as noted above.

DISCUSSION

In furtherance of Policy D-140.954, two external consultants with substantial expertise in this area were immediately engaged. The purpose of engaging two separate consultants was to ensure that legal and operational points of view were both considered, and that any recommendations would reflect a common view of best practice, rather than a single evaluation. The consultants reviewed and evaluated Policy H-140.837, “Anti-Harassment Policy,” and compared it to current best practices as well as policies and procedures currently in use by other membership societies. The consultants’ review considered the policy in two parts – i) the anti-harassment policy itself, and ii) the procedures to implement the policy.

The consultants observed that the AMA’s existing anti-harassment policy includes the critical elements of an effective policy (the first of the two parts mentioned above): a clear definition of unacceptable conduct; a clear statement of when, where, and to whom the policy applies; a statement that retaliation for reporting violations of the policy is itself a violation of the policy; and a statement that reports of violations will be kept confidential to the extent possible. Thus, the consultants were complimentary of this first portion of the policy, and recommended only modest changes (see “Consultants’ recommendations for revision of the policy,” below). However, the consultants noted that the current policy also includes material that more properly belongs in a detailed “enforcement procedures” document, and that the implementation procedures described in the existing policy (the second of the two parts mentioned above) do not entirely reflect current best practices. The consultants therefore recommended more substantive revisions to these procedural aspects of the policy (see “Consultant recommendations for changes to implementation and enforcement of the policy – Operational Guidelines,” below.)

Below are the consultants’ specific observations and joint recommendations.

Consultants’ recommendations for revision of the policy

The consultants recommend that the name of the policy be changed to “Policy on Conduct at AMA Meetings and Events.” The reasons for this recommendation are:

• It more accurately captures a comprehensive objective to promote respectful, professional, and collegial behavior at AMA meetings and events and to effectively address violations of the policy.
• It avoids confusion as to what the policy covers. Most people equate “anti-harassment” policies or trainings with anti-sexual harassment. Although this policy addresses sexual harassment, it is much broader in scope and includes a prohibition of harassment on the basis of characteristics other than sex or gender.

The consultants recommend that the current policy be retained, with the following additions:

• A statement that the purpose of the policy is to protect participants in AMA activities from harm
• A description of desired behavior in interactions, for example:
  o Exhibit professional, collegial behavior at all times
Exercise consideration and respect in your speech and actions, including while making formal presentations to attendees.

- Be mindful of one’s surroundings and of fellow participants.
- Alert meeting Chair or meeting organizer of violations of the anti-harassment policy – even if they seem inconsequential.

- A statement about potential consequences for violation of the policy. For example: If a participant engages in unacceptable behavior at an AMA meeting or event, AMA reserves the right to take any action deemed appropriate based on the outcome of the incident investigation(s). This action may include but is not limited to:
  - Removing the violator from the AMA event or activity, without warning or refund;
  - Prohibiting the violator from attending future AMA events or activities;
  - Removing the violator from leadership or other roles in AMA activities;
  - Prohibiting the violator from assuming a future leadership or other role in AMA activities;
  - Revoking the violator’s membership in the AMA, following the CEJA processes for taking such an action;
  - Notifying the violator’s employer of the actions taken by AMA; and/or
  - Notifying law enforcement.

The consultants recommend the implementation of processes and tactics to help ensure that attendees of AMA meetings and events are made aware of the policy and consequences for violations of the policy, and mechanisms by which attendees affirmatively acknowledge and assent to the policy.

The consultants recommend that the sections of the policy beginning with “1. Reporting a complaint of harassment” through “3. Disciplinary Action” be replaced with Operational Guidelines as described below.

**Consultant recommendations for changes to implementation and enforcement of the policy – Operational Guidelines**

The current policy includes detailed procedures for reporting, investigation, and enforcement of the policy. However, the procedures described in the policy do not entirely reflect current best practices in implementation and enforcement of such a policy. In addition, implementation of these procedures would be cumbersome and unlikely to bring about the desired outcome of making AMA meetings and events safer and more welcoming to all participants.

Current best practices for implementation and enforcement include:

1. Ensuring awareness, acknowledgement and acceptance of the policy by meeting/event participants.
2. Simple and straightforward ways to report violations of the policy at the time of (or very close in time to) the incident in question.
3. Independence and neutrality in investigation of violations of the policy.
4. Avoidance of even the appearance of conflicts of interest in decisions on consequences for violations of the policy.
5. Assurance that all reports of violation and the outcomes of investigations will be reported to the organization’s counsel.
6. Assurance that reports, investigations, and outcomes will be kept confidential to the fullest extent possible, consistent with usual business practices.
The consultants further recommend that the policy be amended to reflect the need for flexibility in procedures for receiving reports, investigating incidents, and making decisions on consequences. This flexibility is necessary because of the wide range of meetings and activities covered by the policy, including consideration of the purpose, size and duration of meetings and activities.

Specifically, the consultants recommend adoption of the following operational guidelines for reporting, investigation, and enforcement of the policy.

**Violation Reporting Procedures**

In order to encourage individuals who are targets of harassment to report incidents, it is important to have a simple, straightforward, and easily publicized reporting mechanism. Ideally, reports should be taken and investigated by a single individual who is unlikely to face conflicts of interest in this role.

The consultants recommend that the AMA bring in an independent consultant to act as the Conduct Liaison for larger meetings and events. This should be someone who is trained and experienced in handling incidents of harassment and bullying. The Conduct Liaison should be the primary point of contact for event participants to report violations of the policy, and responsible for any on-site investigations of those violations. The Conduct Liaison should provide recommendations for immediate action to the Event Chair or other senior designated AMA officer or representative involved in the AMA meeting in question, and should provide a formal report with recommendations for any further action to the Committee on Conduct at AMA Meetings and Events (CCAM, see below). All reported violations of the policy, and the outcomes of investigations by the Conduct Liaison, should be provided to the Office of General Counsel.

For smaller meetings, the role of the Conduct Liaison may be assumed by an individual designated by the AMA Office of General Counsel and trained in advance of assuming such role, who may or may not be physically on-site at the meeting. If not on-site, the Conduct Liaison should be on-call.

The consultants recommend retaining the requirement for a reporting hotline in addition to the Conduct Liaison, which will be an alternative source for meeting attendees to lodge complaints regarding conduct at meetings.

**Investigation of Incidents**

Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event in order to provide recommendations for action to the CCAM.

Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

**Committee on Conduct at AMA Meetings and Events (CCAM)**

The consultants recommend the establishment of a Committee on Conduct at AMA Meetings and Events (CCAM), to include 5-7 members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The consultants recommend that the CCAM should include one member of the
Women Physicians Section (WPS), and one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally. Emphasis should be placed on maximizing the diversity of membership.

The consultants recommend that the CCAM receive reports on all violations of the policy arising from any AMA meeting or event. When an incident is significant enough that it requires action beyond those taken on-site at the event, the CCAM reviews the incident reports, performs further investigation if needed, and makes recommendations regarding further commensurate sanctions to the Office of General Counsel and to the appropriate AMA body (e.g., meeting or event organizers, appropriate AMA staff, and/or CEJA).

To prevent possible retaliatory action against CCAM members, all proceedings of the CCAM should be kept as confidential as practicable.

CONCLUSION

As noted above, consultants engaged by the AMA in furtherance of Policy D-140.954 have reviewed and evaluated the AMA’s current Anti-Harassment Policy (Policy H-140.837) and confirmed that this existing policy includes many of the critical elements of an effective anti-harassment policy. However, while the current policy includes detailed procedures for reporting, investigation, and enforcement, several amendments to the policy are necessary to bring it fully in line with current best practices in implementation and enforcement. The consultants suggested that implementation of the existing procedures would be cumbersome and unlikely to bring about the desired outcome of making AMA meetings and events safer and more welcoming.

The consultants have recommended modifications to ensure that the policy itself, and the procedures for reporting, investigation and enforcement of the policy, reflect current best practices. In particular, the consultants’ recommended modifications are intended to ensure 1) simple ways to report violations, 2) prompt investigation and resolution of alleged violations, 3) independence and neutrality in investigation of violations, and the avoidance of conflicts of interest, and 4) flexibility in procedures for receiving reports, investigating incidents, and making decisions on consequences of the policy (recognizing the nature, number and varying size of AMA meetings conducted each year).

The Board of Trustees has carefully considered the recommendations of the consultants, and believes that these recommendations are consistent with the goals and objectives of the AMA’s current Anti-Harassment Policy and will result in significant improvements to help ensure that AMA meetings and events are safe and welcoming to all participants. The Board of Trustees also believes that these recommendations are responsive to comments and concerns expressed at the 2018 Interim Meeting. Therefore, the Board of Trustees is recommending corresponding modifications to Policy H-140.837, “Anti-Harassment Policy,” as set forth below.

RECOMMENDATION

The Board of Trustees recommends the following, and that the remainder of this report be filed:

1. That Policy D-140.954, “Harassment Issues Within the AMA,” be rescinded as having been fulfilled by the report. (Rescind HOD Policy)
2. That Policy H-140.837, “Anti-Harassment Policy,” be renamed “Policy on Conduct at AMA Meetings and Events” and further amended by insertion and deletion as follows (Modify Current HOD Policy):

**Anti-Harassment Policy Applicable to AMA Entities**

**Policy on Conduct at AMA Meetings and Events**

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA staff, fellow delegates or others by members of the House of Delegates or hosted meeting, event and other attendees at or in connection with HOD meetings, or otherwise activity, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, an AMA hosted meeting, event or activity is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

**Definition**

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

**Sexual Harassment**

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any
AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

**Operational Guidelines**

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. **Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)**

   The Office of General Counsel will appoint a “Conduct Liaison” for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

   The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. **Reporting Violations of the Policy**

   Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings...
of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or
JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such
meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s)
of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and
online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will
provide an option to report anonymously, in which case the name of the reporting party
will be kept confidential by the vendor and not be released to the AMA. The vendor will
advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, “Policy on Conduct at AMA Meetings and
Events,” pursuant to Section 2 above (irrespective of the reporting mechanism used) will
be investigated by the Conduct Liaison. Each reported violation will be promptly and
thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident
investigations on-site during the event. This allows for immediate action at the event to
protect the safety of event participants. When this is not possible, the Conduct Liaison may
continue to investigate incidents following the event to provide recommendations for
action to the CCAM. Investigations should consist of structured interviews with the person
reporting the incident (the reporter), the person targeted (if they are not the reporter), any
witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the
Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the
outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the
AMA’s Office of General Counsel (i.e. irrespective of whether the Conduct Liaison
determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA
Meetings and Events has occurred, the Conduct Liaison may take immediate action to
protect the safety of event participants, which may include having the violator removed
from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at
AMA Meetings and Events has occurred, the Conduct Liaison shall report any such
violation to the CCAM, together with recommendations as to whether additional
commensurate disciplinary and/or corrective actions (beyond those taken on-site at the
meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and
recommend to the Office of General Counsel any additional commensurate disciplinary
and/or corrective action, which may include but is not limited to the following:
- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator’s employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

1. Reporting a complaint of harassment

Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.
Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice-Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.

Fiscal note: $75,000-$100,000 for Conduct Liaison fees and travel expenses, as well as potential meeting costs for the Committee on Conduct at AMA Meetings and Events.
APPENDIX A

Biographies

AMY L. BESS, J.D. has practiced in the area of employment defense for more than thirty years and currently serves as Chair of the global Labor and Employment practice group for Vedder Price and is a member of firm’s Board of Directors.

Her employment litigation experience includes the representation of employers before U.S. state and federal courts and administrative agencies, defending against claims of race, sex, disability and age discrimination; sexual harassment; whistleblower retaliation; restrictive-covenant disputes; wrongful termination; and wage and hour violations. She regularly counsels clients in all of these areas, drafts and negotiates employment and severance agreements, conducts on-site workplace investigations, presents training seminars and speaks to employer groups on avoiding workplace problems. Ms. Bess is an author and frequent speaker on a variety of employment topics, most notably on the impact of the #MeToo movement and anti-harassment laws and best practices organizations should undertake to prevent and resolve harassment concerns. She is regularly quoted in the media on these and related topics.

Select Publications


“Oops, He (or She) Did It Again! Implementing a Best-In-Class Harassment-Free Workplace Program to Help Your Company Stay Out of the Headlines” Employee Relations Law Journal, Winter 2017


Select Speaking Engagements

Conference Co-Chair/Moderator, “Employment Law Lessons Learned from Recent Scandals” PLI Employment Law Institute 2018, October 2018, New York, NY

"Vedder Talk: Lessons Learned from the #MeToo Movement" 2018 Vedder Works Employment Law Series, October 2018, Washington, D.C.

“Advising Clients on Sexual Harassment Law in the #MeToo Era” DC Bar, July 12, 2018


“Employee Relations in the #MeToo Era: Creating a Culture of Respect” 2018 Vedder Works Employment Law Series: April 24, Chicago, IL and June 1, Chicago–O’Hare, IL, June 14, New York, NY

“Sexual Harassment: Lessons Learned from Recent Scandals” PLI Sexual Harassment Webcast, November 2017

“Conducting and Documenting Investigations and Termination Actions” 2014 Vedder Price Employment Law Update: Rosemont, IL
SHERRY A. MARTS, PH.D., CEO of S*Marts Consulting LLC, is a former association CEO with a wide-ranging background in biomedical research, nonprofit management, public education, and research advocacy. Sherry provides expert consulting services to nonprofits and academic institutions on diversity and inclusion, harassment and bullying, and interpersonal communication. Her work includes a particular focus on harassment and bullying at professional society meetings and conferences. She provides training for society and association staff on how to implement and enforce meeting codes of conduct. She also leads workshops on active bystander intervention, harassment resistance, and ally skills. Her interest in the issue of harassment and bullying lies at the intersection of her professional life as a woman in science, and her previous experience as a women’s self-defense instructor.

Sherry is the recipient of the 2018 MIT Media Lab Disobedience Award.

Select Publications


“Include is a Verb: Moving from Talk to Action on Diversity and Inclusion,” available at http://bit.ly/2peWwP0

“The Book of How: Answers to Life’s Most Important Question.”

Dr. Marts received her B.Sc. (Hons.) in Applied Biology from the University of Hertfordshire, and her Ph.D. in Physiology from Duke University.
APPENDIX B

AMA Policy H-140.837, “Anti-Harassment Policy”

1. Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each
complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA’s Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.
At the 2018 Interim Meeting, Policy G-600.016, “Data Used to Apportion Delegates G-600.016,” was adopted. It states that:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each national medical specialty and state medical society of its current AMA membership count status report.

2. “Pending members” will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to national medical specialty and state medical societies for the following year.

3. Our AMA Physician Engagement department will develop a mechanism to prevent a second counting of those previous “pending members” at the end of the following year until their membership has been renewed.

Reporting mid-year membership counts to state medical societies as called for in paragraph 1 of the policy is a straightforward process and will be implemented within one month following the conclusion of the 2019 Annual Meeting of the House of Delegates. Because current Policy G-600.027 links the total number of national medical specialty society delegates to the overall number of constituent (i.e., state) association delegates and because membership counts for most national medical specialty societies are based on their most recent five-year review, membership figures will be unchanged from the apportionment data for all national medical specialty societies other than those that undergo a five-year review at the just concluded Annual Meeting. Accordingly, your Board of Trustees offers an alternate recommendation to clarify mid-year reporting.

The remainder of this report deals primarily with implementation of the second and third paragraphs of Policy G-600.016.

APPORTIONMENT OF DELEGATES

Under current AMA Bylaws (2.1.1), constituent associations are apportioned delegates at the rate of one delegate for each 1000 (or fraction thereof) active AMA members within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year. Thus, for example, a constituent association with 1000 or fewer AMA members is apportioned one delegate and one alternate delegate, while a constituent association with from 1,001 to 2,000 AMA members will receive two delegates and two alternate delegate seats. (Some other bylaws provisions deal with special circumstances such as a loss of AMA members by the constituent association, but...
those are not relevant for purposes of this report.) For 2019, 281 delegates were apportioned to
collective associations, which in turn means that 281 delegates were apportioned to national
medical specialty societies using methods specified in Policy G-600.027, “Designation of Specialty
Societies for Representation in the House of Delegates.” For both constituent associations and
national medical specialty societies membership figures are calculated as of December 31 and
delegates are apportioned for the following year. While actual end-of-year counts are used for
constituent associations, national medical specialty society data generally come from the most
recent five-year review.

Apportionment Under Policy G-600.016

Although the plan described below was adopted by the House of Delegates at I-18, no changes in
delegate apportionment are possible until the AMA Bylaws are amended. The figures in
Appendix 1 for the (hypothetical) 2019 delegate apportionment to constituent associations are
based on this plan. Because national specialty society delegate apportionment is hinged to
constituent associations, national specialty societies are not included in the table.

The definition of “pending members” referenced in paragraph 2 of Policy G-600.016 is critical to
understanding apportionment under the new policy. Board of Trustees Report 1-I-18, which
eventuated in Policy G-600.016, defined pending members as individuals who at the time they
apply for membership are not current in their dues and who pay dues for the following calendar
year. For example, a nonmember in 2018 who during calendar year 2018 completed an application
and paid dues for the 2019 membership year would be a “pending member.” In practical terms, a
pending member’s active membership is not in effect on December 31, only becoming active the
next day. Under current rules, those members are not reported as members in any end-of-year
statistics. Pending members typically acquire “pending” status in the fourth quarter of a given year.
Under Policy G-600.016 “pending members” will be added to the active members as of December
31 to determine delegate allocation for the following year.

The figures in the two rightmost columns of Appendix 1 were calculated using this plan, which
counts both active and pending members for purposes of delegate apportionment. This count will
differ from the membership reported in the annual “Performance, Activities and Status” report
(BOT Report 7 at this meeting).

As is apparent from Appendix 1, the inclusion of pending members will result in ten new delegates.
Thereafter, the plan will have relatively few effects. This is so for two reasons. As noted, delegates
are apportioned at the one per 1000 members rate, so for a constituent association to gain a
delegate, the number of pending members must move its member count across a 1000 threshold.
The likelihood of that for any given constituent society after the first year when a few societies that
are close to the threshold see a positive effect is low. At the same time, the number of pending
members must more than offset the number of active members who do not renew their
memberships for the succeeding year to have an ongoing positive effect.

It is critical to avoid any gaming of the system. Consider a nonmember who becomes a pending
member late in the year. As a pending member, that individual enters into the apportionment
calculations for the succeeding year, and as a then current member would also be included in the
counts for the next year as well. The following chart shows how someone joining late in the year
every other year would affect delegate apportionment.
Insofar as AMA membership benefits ought to accrue to members, and our members report that representation and advocacy on their behalf are highly valued, it is critical that apportionment be based on members, not individuals seeking to game the system. Paragraph 3 of Policy G-600.016 attempts to resolve the issue by calling for the development of a mechanism to prevent a second counting of these members the following year until they have renewed their membership. To ensure that a “pending member” who only pays membership for a single year is not counted for apportionment for two years, our AMA will track each “pending member” (who will be added to the membership count for purposes of delegate apportionment in the year in which they paid membership dues for the following year, as per paragraph 2) and, as specified in paragraph 3, they will not be counted in the subsequent year’s apportionment unless they renew their membership before the end of the following year. Once a “pending member” has renewed their membership for the following year, going forward they will be counted like all other active members and will no longer be tracked. While your Board of Trustees recognizes that it is still possible to “game” this system, continued tracking of an increasing cohort of “pending members” presents an ever-increasing data burden.

Our AMA currently reports active membership for any given year and over the course of the calendar year for a variety of reasons. We do not currently track “pending members” and certainly do not follow these members prospectively. Implementation of Policy G-600.016 will require an internal process to perform tracking of these individual members. Because the impact upon our AMA and the constituent societies of the House of Delegates of this new apportionment methodology beyond the first year is unknown and the data challenges to track pending members as they renew for subsequent years are difficult to determine prospectively, your Board of Trustees recommends that Policy G-600.016 be amended to reflect a trial period with a report back on the impact and recommendations for the future be submitted to the House of Delegates at the 2022 Annual Meeting.

CONCLUSION

Your Board of Trustees has prepared this report to ensure clarity with respect to the yet to be implemented plan for delegate apportionment outlined in Policy G-600.016 and to afford members of the House of Delegates an opportunity to provide additional input via the reference committee process. Moreover, because apportionment is effective for a calendar year, Bylaws amendments at the upcoming Interim Meeting will allow timely execution of the policy.

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<td>7</td>
<td>Year 5</td>
<td>Pending</td>
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RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:

A. That Policy G-600.016, “Data Used to Apportion Delegates,” be amended to read as follows:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review and state medical society of its current AMA membership count status report. (New HOD Policy)

2. “Pending members” will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to national medical specialty and state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity. (New HOD Policy)

3. Our AMA Physician Engagement department will develop a mechanism to prevent a second counting of those previous “pending members” at the end of the following year until their membership has been renewed. (Directive to Take Action)

4. Our AMA will track “pending members” from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year. (New HOD Policy)

4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy. (Directive to Take Action)

B. That the Council on Constitution and Bylaws prepare a report for the 2019 Interim Meeting that will allow the implementation of Policy G-600.016, as amended herein.

Fiscal Note: $8,695
APPENDIX 1

Constituent Association Delegate Apportionment: 2019 Actual and 2019 Hypothetical

<table>
<thead>
<tr>
<th>Constituent Association</th>
<th>AMA members as of 31 Dec 2018</th>
<th>Apportionment 2019</th>
<th>AMA members including pending members</th>
<th>2019 hypothetical apportionment</th>
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<td>-</td>
<td>749</td>
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1. Kansas had three delegates in 2018 and can retain the third delegate by submitting a plan for intensified membership recruitment. See bylaw 2.1.1.1.1.
2. Figures do not include delegates awarded under special bylaws provisions (e.g., provisions for the speaker and vice speaker).
Policy G-600.027, “Designation of Specialty Societies for Representation in the House of Delegates”

1. 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. 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.

Bylaw B-2.1, “Constituent Associations”

Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.1.2. Only one constituent association
from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 Apportionment. The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.1.1.1.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

2.1.1.2 Unified Membership. A constituent association that adopts bylaw provisions requiring all members of the constituent association to be members of the AMA shall not suffer a reduction in the number of delegates allocated to it by apportionment during the first 2 years in which the unified membership bylaw provisions are implemented.

2.1.2 Additional Delegates. A constituent association meeting the following criteria shall be entitled to the specified number of additional delegates.

2.1.2.1 Unified Membership. A constituent association shall be entitled to 2 additional delegates if all of its members are also members of the AMA. If during any calendar year a constituent association adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the constituent association shall be entitled to the 2 additional delegates. The constituent association shall retain the 2 additional delegates only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that all of the constituent association’s members are members of the AMA.

2.1.2.2 Minimum 75% Membership. A constituent association shall be entitled to one additional delegate if 75% or more of its members, but not all of its members, are members of the AMA. The constituent association shall retain the additional delegate only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that 75% or more of the constituent association’s members are members of the AMA. If the membership information indicates that less than 75% of the constituent association’s members are members of the AMA, the constituent association shall be permitted to retain the additional delegate for one additional year if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. If the membership information for the constituent association, as recorded by the AMA as of the following December 31 indicates that for the second successive year less than 75% of the constituent association’s members are members of the AMA, the constituent association shall not be entitled to retain the additional delegate.

2.1.2.3 Maximum Additional Delegates. No constituent association shall be entitled to more than 2 additional delegates under Bylaw 2.1.2.
2.1.2.3.1 Effective Date. The additional delegates provided for under this bylaw shall be based upon membership information recorded by the AMA as of December 31 of each year. Allocation of these seats shall take effect on January 1 of the following year.

2.1.3 Selection. Each constituent association shall select and adjust the number of delegates to conform with the number of seats authorized under this bylaw.

2.1.4 Certification. The president or secretary of each constituent association shall certify to the AMA the delegates and alternate delegates from their respective associations. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

2.1.5 Term. Delegates from constituent associations shall be selected for 2-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.1.6 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

2.1.7 Resident/Fellow Physician and Medical Student Delegates. A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.1.7.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term beginning as of the date of certification of the delegate or alternate delegate by the constituent association to the AMA.

2.1.7.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.5.

2.1.8 Application by a Constituent Association for Representation in the House of Delegates. A constituent association seeking representation in the House of Delegates shall submit an application to the AMA. The Board of Trustees shall make a recommendation to the House of Delegates as to the proposed constituent association’s qualifications for representation, based on all the current guidelines for representation in the House of Delegates.
Subject: Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion (Resolution 607-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F (Greg Tarasidis, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 607, “Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion,” to the Board of Trustees. Resolution 607, introduced by New York Delegate, Dr. Gregory L. Pinto, asked:

That our American Medical Association (AMA) investigate mechanisms by which Members may receive a discount or waiver on CPT-related fees, specifically the fees associated with using CPT codes within electronic medical billing systems.

BACKGROUND ON AMA MEMBERSHIP DUES AND BENEFITS

As the largest association of physicians and medical students in the United States, the AMA provides a wide range of benefits and services to its members. In turn, members pay annual dues in accordance with their career progression, from medical students to residents and fellows to physicians. For example, dues applicable to first year medical school students are less than those applicable to physicians. Membership dues applicable to physicians are graduated over their first five years in practice, such that physicians pay full regular practice dues (i.e. $420) only after four years of medical practice. The AMA seeks to support physicians in the most prudent and direct ways possible. The AMA typically offers its physician members discounts on AMA-developed products sold directly to those members, such as published books, journals and newsletters.

EXPLANATION OF CPT LICENSING AND ROYALTIES

The Current Procedural Terminology (CPT) code set user-base is diverse and varied, and the AMA does not distinguish different types of users from one another, e.g., a nurse and a medical claims specialist both use CPT. In fact, approximately two-thirds of CPT users are not eligible for AMA membership because they are not physicians or medical students. CPT is typically licensed by organizations for all users of CPT – irrespective of user type – and the AMA does not receive information identifying the individuals covered under an organization’s license.

Additionally, the majority of CPT licensing is completed by third party distributors such as software vendors (e.g., vendors of electronic medical billing systems) that embed CPT in their products to enable critical healthcare functions. Hundreds of such organizations contract with the AMA to distribute CPT domestically and globally. Distributor agreements specify a method of calculating a royalty due to the AMA from the distributor, but do not dictate the amount of CPT royalties (if any) to be charged by the distributors to their client, i.e. the end users of CPT. The AMA also does not dictate how distributors contract with their end user customers and these

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practices vary widely. Some distributors elect to absorb the cost of CPT royalties paid to the AMA, or embed the cost into the cost of their product(s), while others choose to directly pass the cost through to their customers. Some distributors license their software (and in turn CPT) based on aggregate user counts, do not track the identities of specific users, and as a result, are unaware of an individual physician’s usage of their product or that physician’s membership status with the AMA.

As for CPT licensees who contract directly with the AMA (rather than through a distributor), most are large or mid-sized health systems, hospitals or practices. As mentioned above, the AMA does not receive information identifying specific users covered under the CPT license and thus is not able to confirm which users are physicians and whether any such physician user is an AMA member. We note that small practices with 25 or fewer CPT users are currently eligible for CPT royalty discounts between 13 and 22% when an AMA physician member purchases the license directly from the AMA, as AMA physician membership can be confirmed in this limited situation. The discount is applied to the entire license, not just the pro rata portion related to the individual physician member.

DISCUSSION

The CPT code set is a mission-driven product, which means that its royalties, like those from *JAMA* and other AMA assets, are used to carry out the mission to promote the art and science of medicine and the betterment of public health, to the benefit of all physicians and patients.

Development of a new CPT licensing and distribution process to administer a membership-based discount is at best impractical, requiring a complete reinvention of the AMA’s licensing and distribution model, renegotiation of hundreds of contracts, and the introduction of cumbersome business processes that AMA’s distributors are unlikely to accept. It would also require high volume and high frequency exchange of sensitive data and a large data reconciliation process. This approach would be inefficient, burdensome and costly for the AMA, the AMA’s distributors and the distributors’ licensees. Even if these significant changes were undertaken, it is unclear that savings would be delivered to AMA members, as distributors (often commercial companies) have different interests than membership organizations.

CONCLUSION

The AMA enhances its ability to achieve its mission by managing its assets in a fiscally prudent manner. Expanding CPT discounts beyond direct licensees would present significant policy, operational and contractual challenges that would divert resources from other important endeavors and result in unnecessary cost to the AMA. It is also very likely that the benefits of these discounts would accrue to distributors or licensee organizations rather than to AMA member physicians.

RECOMMENDATION

Through the analysis that led to this report, an opportunity was identified to improve AMA member benefits for direct licensees with 25 or fewer users by increasing their discount to 30%. This change will go into effect for the 2020 CPT data file. The increased discount will enable the AMA to continue to support its mission, while having a positive impact on AMA members in small practices. This is also consistent with other AMA Membership discount programs. Consequently, the Board of Trustees recommends that Resolution 607-A-18 not be adopted and that the remainder of this report be filed.

Fiscal note: None
EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-65.989 (1), “Advancing Gender Equity in Medicine,” directs our AMA to “draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.” This report responds to this directive by: 1) describing issues associated with gender bias; 2) summarizing AMA positions and recommendations to promote gender equity in medicine; and 3) providing instructive principles for state and specialty societies, academic medical centers and other entities that employ physicians.

Gender-based disparities in compensation and advancement are pervasive in all medical practice settings, specialties, and positions. Research findings have noted that significant differences in salary exist after accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue.

The AMA recognizes that gender inequity in medicine is a complex issue that requires a multilayered approach. Promoting gender equity in medicine requires an acknowledgement of the underlying causes of gender based disparities, creation of policies and resources that will promote gender equity, and collaboration to improve the environment for women and the profession overall.

This report offers principles intended to provide guidance on various issues associated with gender inequities in medicine. This report further recommends the development of policies and processes by various organizations to address harassment and discrimination.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-19

Subject: Advancing Gender Equity in Medicine

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

INTRODUCTION

American Medical Association (AMA) Policy D-65.989 (1), “Advancing Gender Equity in Medicine,” directs our AMA to “draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.” This report responds to this directive.

AMA Policy D-65.989 was created following the adoption of Substitute Resolution 10-A-18, which was adopted in lieu of Resolution 10-A-18, “Advancing Gender Equity in Medicine;” Resolution 11-A-18, “Women Physician Workforce and Gender Gap in Earnings – Measures to Improve Equality;” Resolution 20-A-18, “Advancing the Goal of Equal Pay for Women in Medicine;” and Resolution 21-A-18, “Taking Steps to Advance Gender Equity in Medicine.” Testimony in support of these items before the reference committee acknowledged the problem of gender disparities in medicine and noted a need for study. Testimony also reflected the need for our AMA to set an example on this issue, by committing to pay equity for its employees.

This report: 1) describes issues associated with gender bias; 2) summarizes AMA positions and recommendations to promote gender equity in medicine; and 3) provides clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians.

BACKGROUND

Gender disparities in advancement and income are pervasive in medical practice settings, specialties, and positions. Significant differences in salary exist after accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue. Advancement for women physicians has been slower than would be anticipated despite the growing number of women in medicine.

According to the U.S. Bureau of Labor Statistics, women earned about 82 percent of what men earned among full-time workers in all industries. The gender pay disparity is indicative of “how far our nation still has to go to ensure that women can participate fully and equally in our economy,” according to a report from the National Partnership for Women and Families.

Gender-based disparities in income and advancement are also prevalent in medicine. The 2018 Medscape Physician Compensation Report noted considerable gaps in pay, with female physicians
in primary care earning nearly 18 percent less ($36,000) than their male counterparts. Among
physicians the pay disparity was more pronounced with females earning 36.1 percent less
($95,000) than their male counterparts. This income disparity was consistent across all medical
specialties.3

Ly, Seabury, and Jena conducted an analysis on income disparities among physicians, stratified by
race and gender. Study results identified a considerable pay gap among black and white male
physicians. The study also found that the income of black and white female physicians is “similar,
but significantly lower than the incomes of male physicians.”4

In the United States, women represent more than one third (35.2%) of the active physician
workforce,5 nearly half (45.6%) of all physicians-in-training6 and more than half (50.7%)7 of all
entering medical students in MD-granting medical schools. Although the number of women
entering the medical field has steadily increased, their proportion of leadership positions continues
to be small. In a 2015 survey, women physicians (n = 3,285) identified the leadership positions
they held as: medical director (35%), practice owner (23%), practice partner (13%), CEO (3%), and
CMO (3%).8

Gender Disparities in Academic Medicine

A study of 10,241 physicians in 24 U.S. public medical schools found the annual salaries of female
physicians were lower than those of male physicians, even after adjusting for “age, experience,
specialty, faculty rank, and measures of research productivity and clinical revenue.” This study
noted that “sex differences in salary were present at all faculty ranks and were largest among full
professors.” The average salary difference among male and female full professors was $33,620.
Further, the adjusted salaries of female full professors (averaging $250,971) were comparable to
those of male associate professors (averaging $247,212).9

Another study compared faculty income at 24 medical schools over a 17-year period and found that
female physicians in academic medicine earned on average $20,000 less per year than their male
counterparts. That is to say, female physicians earned 90 cents for every dollar made by male
physicians.10 These findings adjusted for factors such as specialty, experience, and faculty rank.

In addition to salary disparities, leadership disparities exist as well, with female physicians
underrepresented in the higher ranks of medical school faculty. Although women accounted for
41.3 percent of full-time medical school faculty in 2018, they made up only 25 percent of tenured
faculty (of all ranks) and only 24.6 percent of full professors and 37.5 percent of associate
professors.11, 12 Female physicians were also underrepresented in leadership positions at medical
schools. Eighteen percent of department chairs (permanent and interim)13 and eighteen percent of
deans (permanent and interim) were women.14

DISCUSSION

Despite the increasing number of women physicians, gender-based differences in compensation
and advancement exist in the medical profession. Researchers have cited factors such as specialty,
experience, productivity, and work status as the reasons for these disparities. However, study
results indicate that gender disparities persist even when controlling for age, specialty and practice
characteristics. The following issues, which are often associated with gender inequities in
medicine, have been highlighted for discussion.
Women in medicine frequently encounter implicit and overt forms of gender bias as well as discrimination throughout their training and careers. Gender bias and discrimination can have a harmful effect on the professional experiences of women and impact opportunities for advancement such as promotions, grant awards, and manuscript acceptance. The formation of productive relationships with colleagues and mentors is often hindered by gender bias and discrimination. Study findings and anecdotal accounts have cited that women physicians are more likely to be disrespected by colleagues, held to a higher standard than male peers, introduced by their first names instead of professional titles, and excluded from events such as grand rounds.15

Adesoye, Mangurian, Choo, et al. conducted a study of physician mothers to assess their experiences with workplace discrimination. More than three quarters (77.9%) of the respondents stated that they experienced some form of discrimination. Of those respondents, 66.3 percent reported gender discrimination and 35.8 percent reported maternal discrimination, which is defined as self-reported discrimination based on pregnancy, maternity leave or breastfeeding. Almost ninety percent (89.6%) of respondents who reported maternal discrimination noted that it was based on pregnancy or maternity leave. Nearly 48.4 percent of these respondents believed the discrimination was tied to breastfeeding. Those reporting maternal discrimination cited they experienced disrespectful treatment by nursing or other support staff, exclusion from administrative decision making, and gender disparities in salary and benefits.16

Implicit bias, explicit bias, stereotype threat and unconscious self-bias have implications for women as they may influence decisions on hiring, promotion, and compensation. Women may experience higher social costs for engaging in job negotiations and are less likely to negotiate.17 Further, statistical discrimination is often associated with the stereotype that “women are less productive during childbearing years” and contributes to beliefs that women are less likely to aspire to leadership positions or assume roles with higher pay (e.g., undesirable call shifts).18

Mentorship and Sponsorship Opportunities

Women in medicine continue to be underrepresented in leadership positions. It has been noted that guidance and support from mentors and sponsors can positively impact career advancement. Mentorship and sponsorship can also mitigate the professional isolation that can undermine one’s sense of confidence and belonging. However, there is a key distinction between mentorship and sponsorship. Mentors can work at any level in the organization and are selected based on expertise. Sponsors have a position of power that enables them to have significant influence on advancement decisions.

According to Ibarra et al., women tend to be “over-mentored but under-sponsored.”19 Although sponsorship has been positively associated with career advancement, women are typically sponsored less frequently than men. Hewlett et al. found that 13 percent of women had sponsors compared to 19 percent of men.20 Similar to mentorship, there was a difference in outcomes for women and men. For example, an analysis of the National Institutes of Health (NIH) grant recipients found that sponsorship was correlated with success. Seventy-two percent of men and 59 percent of women who reported sponsorship were successful in obtaining an NIH grant compared to 57.7 percent of men and 44.8 percent of women who did not report sponsorship.21

Research findings have shown that mentorship and sponsorship outcomes vary for women and men, with women lagging on career advancement metrics. This may, in part, be attributed to men and women having different experiences with mentors. A study of graduates from top business
schools found that men were more likely to be mentored by someone from senior executive level
positions (62% of men compared to 52% of women). After a two-year follow-up, it was found that
men earned $9,260 more than women annually and were promoted 15 percent more often.22

Work-Life Balance

Many female physicians report work-life balance as a significant concern that may influence their
career choices. This may be reflected in the disproportionate number of women physicians who
choose part-time or reduced work hours to balance professional and personal life. In a recent
survey, 92 percent of young physicians noted that they believe it is important to have a balance
between work and personal responsibilities. However, only 65 percent felt they have achieved
work-life balance.23

While male physicians are increasingly expressing interest in flexible family leave and work
options, female physicians continue to bear primary responsibility for caregiving and may face
more challenges in aligning their career goals with family needs. Nearly a quarter (22%) of female
physicians reported working part-time compared to twelve percent of male physicians.24 Further, a
2017 study found that hours worked by women physicians with children remained statistically
lower when compared to women physicians without children.25

When professionals reach their mid-40s, many of them assume responsibility for eldercare, or
providing care for older relatives. According to a 2017 Bureau of Labor Statistics report, more than
twenty percent (21.4%) of adults between the ages of 45-54 and nearly a quarter (24.3%) of adults
between the ages of 55-64 provide care for an older relative. This same report notes that there are
currently 41.3 million adults that provide unpaid eldercare and the majority are women (56%).26

Although flexible work options (e.g., part-time work, re-entry, etc.) are intended to balance
professional and personal responsibilities, there is also an impact on income and earning potential.
Additional accommodations, such as flexible scheduling time and re-entry assistance programs,
need to be offered beyond parental and family leave.

Increased Risk of Burnout

Burnout among physicians has been associated with adverse quality outcomes, diminished patient
satisfaction, increased job dissatisfaction, and reduction of work effort. More than half of U.S.
physicians are experiencing symptoms of burnout and the prevalence of burnout in physicians is
nearly two times greater than other professions. Similarly, the prevalence of burnout and
depression among medical students and residents is higher than individuals of similar age.27

Findings from a survey of more than 15,000 physicians from 29 specialties noted that 50 percent of
female physicians reported burnout, compared with 39 percent of their male peers.28 Many factors
contribute to burnout, including administrative burdens, challenges in working with electronic
health records, discrimination, lack of respect, and maintaining work-life balance.

In addition, the conflict between professional and personal responsibilities has been associated with
increasing burnout odds by 200 to 250 percent.29 Women are often disproportionately responsible
for childcare and family responsibilities. Further, maternal discrimination was associated with
higher self-reported burnout (45.9% burnout in those with maternal discrimination compared to
33.9% burnout in those without).30 Ultimately, it has been noted that “less pay combined with
physician burnout might lead to more female physicians leaving the profession.”31
CONCLUSION

The AMA recognizes that gender inequity in medicine is a complex issue that requires a detailed, multifaceted approach. Promoting gender equity in medicine requires an acknowledgement of the underlying causes of gender-based disparities, creation of policies and resources that will promote gender equity, and collaboration to improve the environment for women and the profession as a whole.

Factors such as specialty, experience, productivity, and work status have been attributed to gender-based disparities in compensation and professional advancement. However, researchers have found that these disparities persist even when studies control for age, specialty and practice characteristics. Remaining disparities are attributed to a degree of gender discrimination and gender bias that can have a deleterious effect on the professional experiences of women and impact opportunities for advancement.

The proposed AMA Principles for Advancing Gender Equity in Medicine were derived from a review of current AMA policies on gender disparities, women in medicine, and equal opportunity. These policies were consolidated to ensure that AMA policy on gender equity in medicine is consistent and accurate. The principles being proposed in recommendation 1 incorporate relevant portions of the three existing AMA policies that are recommended for rescission in recommendation 2. Appendix A provides a comparison of the proposed language and the original language that is being modified. Appendix B lists the full text of the polices recommended for rescission.

RECOMMENDATIONS

The AMA recognizes that gender inequity in medicine is a complex, pervasive issue that requires a multilayered approach. Accordingly, the Board recommends that the following be adopted and that the remainder of the report be filed.

1. That our American Medical Association adopt the following language as policy, “Principles for Advancing Gender Equity in Medicine”:

   Our AMA:

   1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

   2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

   3. endorses the principle of equal opportunity of employment and practice in the medical field;

   4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

   5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas. (New HOD Policy)

2. That our AMA rescind the following policies, as they have been incorporated into the “Principles for Advancing Gender Equity in Medicine”:

   b. H-525.992, “Women in Medicine”
   c. H-65.968, “Equal Opportunity” (Rescind HOD Policy)

3. That our AMA rescind AMA Policy D-65.989 (1), “Advancing Gender Equity in Medicine,” as this report has fulfilled the request for information on positions and recommendations regarding gender equity in medicine, including the development of clarifying principles. (Rescind HOD Policy)

4. That our AMA encourage state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine. (Directive to Take Action)

5. That our AMA encourage academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. (Directive to Take Action)

6. That our AMA, modify Policy D-65.989, “Advancing Gender Equity in Medicine,” and continue to: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement. (Modify HOD Policy)
7. That our AMA amend AMA Policy G-600.035, “The Demographics of the House of Delegates,” to read as follows:

   a. 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.

   b. 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.

   c. Future reports on the demographic characteristics of the House of Delegates should, whenever possible, will identify and include information on successful initiatives and best practices to promote diversity within, particularly by age, state and specialty society delegations. (Modify Current HOD Policy)

Fiscal Note: Less than $5,000
REFERENCES


6. Ibid.


18. Ibid.


APPENDIX A: PROPOSED AMA POLICY: “PRINCIPLES FOR ADVANCING GENDER EQUITY” (WORKSHEET VERSION)

Note: The left column shows the proposed language for adoption; the right column shows the original language that is being modified and its policy number, if any.

<table>
<thead>
<tr>
<th>Proposed language for adoption</th>
<th>Original language</th>
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<tr>
<td><strong>Our AMA:</strong> 1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender)</td>
<td><strong>Our AMA:</strong> (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; H-65.968</td>
</tr>
<tr>
<td><strong>2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;</strong></td>
<td><strong>(2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; H-65.968</strong></td>
</tr>
<tr>
<td><strong>3. endorses the principle of equal opportunity of employment and practice in the medical field;</strong></td>
<td><strong>(3) affirms the concept of equal rights for men and women; H-65.968</strong></td>
</tr>
<tr>
<td><strong>4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;</strong></td>
<td><strong>Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine. H-65.968</strong></td>
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<tr>
<td><strong>5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement and encourages physicians to engage in such activities;</strong></td>
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<tr>
<td><strong>6. declares that compensation should be equitable and based on comparable work at each career stage, demonstrated competencies/expertise and not based on personal characteristics;</strong></td>
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<tr>
<td><strong>7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;</strong></td>
<td><strong>Our AMA: (1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist. D-200.981</strong></td>
</tr>
<tr>
<td>8.</td>
<td>affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and</td>
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<tr>
<td></td>
<td>(3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession; D-200.981</td>
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<td>9.</td>
<td>affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas. and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit. D-200.981</td>
</tr>
</tbody>
</table>
**APPENDIX B: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION**

**Equal Opportunity H-65.968**
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

**Gender Disparities in Physician Income and Advancement D-200.981**
Our AMA: (1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist; (2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations; (3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession; (4) will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession; and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

**Women in Medicine H-525.992**
Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine.

**Advancing Gender Equity in Medicine D-65.989 (1)**
Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.
APPENDIX C: STATUS OF DIRECTIVES ASSOCIATED WITH AMA POLICY ADVANCING GENDER EQUITY IN MEDICINE D-65.989

<table>
<thead>
<tr>
<th>Policy Language</th>
<th>Status</th>
</tr>
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<tbody>
<tr>
<td>2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.</td>
<td>AMA PolicyFinder was updated to include Advancing Gender Equity in Medicine D-65.989.</td>
</tr>
<tr>
<td>3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.</td>
<td>Programming will be developed for future AMA meetings.</td>
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<tr>
<td>4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.</td>
<td>A report with recommendations will be provided to the AMA House of Delegates at the 2019 Interim Meeting. This report will be based on data from the 1) Demographic Characteristics of the House of Delegates and AMA Leadership (CLRPD Report 1-A-19) and 2) results from an AMA staff survey used to collect information on committee composition, plenary speaker invitations, recognition awards, and grant funding.</td>
</tr>
<tr>
<td>5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.</td>
<td>An evaluation of gender/demographic equity for pay practices in AMA’s internal workforce is underway.</td>
</tr>
</tbody>
</table>
Whereas, Freedom of speech is essential and all sides of an issue deserve to be discussed; and

Whereas, Our AMA has good policy on most medical issues; and

Whereas, The Aug. 22-29, 2017, JAMA published an editorial on Maintenance of Certification contrary to AMA policy; therefore be it

RESOLVED, That our American Medical Association include a policy statement after all editorials in which policy has been established to clarify our position. (Directive to Take Action)

Fiscal Note: Indeterminate.

Received: 03/06/19

RELEVANT AMA POLICY

AMA Publications G-630.090
AMA policy on its publications includes the following:
(1) JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy.
(2) Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist.
(3) Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article.
(4) The House of Delegates affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.
Whereas, Our American Medical Association House of Delegates (HOD) has adopted Policy H-140.837 declaring that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings and other AMA-sponsored meetings or events is prohibited conduct and is not tolerated; and

Whereas, Our AMA HOD has also adopted Policy D-140.954 calling for an external evaluation of the anti-harassment processes set forth in Policy H-140.837 with a report back at this meeting; and

Whereas, Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any other AMA-sponsored meeting or event; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits; and

Whereas, Harassing conduct includes, but is not limited to epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting; and

Whereas, Our Rules and Credentials Committee proposes and our AMA HOD adopts a rule at every meeting calling for respectful behavior at all times; and

Whereas, Our AMA HOD has collectively recognized the odious nature of harassing behaviors in its prior actions; and

Whereas, Every delegate and alternate delegate should acknowledge their role in preventing harassment at AMA meetings, but particularly at our own HOD meetings, as part of the meeting registration process; therefore be it
RESOLVED, That every AMA HOD delegate and alternate delegate shall, as a condition to receiving their credentials for any AMA HOD meeting, acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies (New HOD Policy); and be it further

RESOLVED, That any AMA HOD delegate or alternate delegate who knowingly fails to acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies shall not be credentialed as a delegate or alternate delegate at that meeting. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/09/19

RELEVANT AMA POLICY

Anti-Harassment Policy H-140.837

Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

**Anti-Harassment Policy**

1. **Reporting a complaint of harassment**

Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. **Investigations**

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. **Disciplinary Action**

If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.
If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.

Citation: BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18

Harassment Issues Within the AMA D-140.954

Our AMA will immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or attendees with report back regarding said processes and implementation at the 2019 Annual Meeting.

Citation: Emergency Res. 01, I-18
Whereas, Members of our AMA House of Delegates cherish our democratic process; and

Whereas, Our current election and voting process for AMA officers and council positions consumes a lot of time and financial resources; and

Whereas, Election reform would allow for more time for policy and debate during HOD sessions; and

Whereas, Cost barriers are often an impediment to candidate elections; and

Whereas, There are significant technological advances that could allow for an expedited process of elections and debate; therefore be it

RESOLVED, That our American Medical Association appoint a House of Delegates Election Reform Committee to examine ways to expedite and streamline the current election and voting process for AMA officers and council positions (Directive to Take Action); and be it further

RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following options:

- The creation of an interactive election web page;
- Candidate video submissions submitted in advance for HOD members to view;
- Eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker and Board of Trustee positions;
- Move elections earlier to the Sunday or Monday of the meeting;
- Conduct voting from HOD seats (Directive to Take Action); and be it further

RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns (Directive to Take Action); and be it further

RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 Interim Meeting with a list of recommendations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is between $15K-$25K.
Whereas, The Joint Commission’s stated mission is “to continuously improve health care for the public in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value”; and

Whereas, The Joint Commission accredits a large number of hospitals in the United States; and

Whereas, Joint Commission standards established in 2000 prioritized pain management (including chronic non-cancer pain) guidelines over the root causes of pain [1]; and

Whereas, The manufacturer of OxyContin is believed to have provided funding for the Joint Commission’s pain management educational programs during the time that these standards were developed; and

Whereas, As a result of these pain standards, the increased use of opioids may have been indirectly encouraged as a way to comply with the guidelines, even though there was little evidence or validation to support the long-term use of narcotics to treat chronic, non-cancer pain; and

Whereas, A very recent Cochrane Review [2] concluded that there is a “paucity of high-quality controlled evaluations of the effectiveness and the cost-effectiveness of external inspection systems”; and

Whereas, Another systematic review [3] came to a similar conclusion, stating that their “review did not find evidence to support accreditation and certification of hospitals being linked to measurable changes in quality of care”; therefore be it

RESOLVED, That our American Medical Association study and report back on any potential impact, influence, or conflicts of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians). (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19
References:

Whereas, According to their website, The Litigation Center is an integral part of the AMA’s advocacy efforts for physicians and their patients, and can help state medical societies or other entities with legal issues of exceptional importance or which have national implications; and

Whereas, ‘Medical societies can benefit from the actions of the Litigation Center in any number of ways, including participation as a party in a lawsuit, filing of an amicus curiae (“friend of the court”) brief, financial grants, or in-kind services. Sometimes, the Litigation Center can help “level the playing field” when a physician feels overwhelmed by the legal system’; and

Whereas, The Litigation Center will on occasion approach a state medical society with an invitation to join in its efforts such as in preparing an amicus; and

Whereas, The AMA Board in consultation with the Litigation Center will interpret the will of or policy of the AMA House of Delegates in setting forth its legal strategy/approach; and

Whereas, There is sometimes a disjunction between the interpretation of AMA policy by the state medical society’s leadership and the attorneys of the Litigation Center--because of the different perspective between attorneys and physicians; and

Whereas, This disjunction can prevent the state medical society from joining the AMA in an Amicus due to this disjunction (despite sharing a desire to achieve a similar outcome); and

Whereas, Typically the AMA recognizes that legal battle would be more effective were the pertinent state medical society to join an AMA amicus; therefore be it

RESOLVED, That when seeking a state medical society’s support of an amicus brief on a legal matter, especially one pertaining to an issue in that state, the American Medical Association Litigation Center consider the state medical society’s point of view in developing the argument, and maintain full disclosure during the drafting of the amicus or any change in strategy.

(Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19
Whereas, Approximately 13% residents and fellows are part of formal unions\(^1\); and

Whereas, The ACGME introduced the Clinical Learning Environment Review (CLER) program in 2012 where teaching hospitals are visited every 18 months\(^1\); and

Whereas, These visits are meant to “gain knowledge about how clinical sites are supporting the training of residents and fellows in the areas of patient safety, health care quality, supervision, transitions in care, duty hours, fatigue management, and professionalism” according to the journal of graduate medical education\(^1\); and

Whereas, The intention of the external program is to allow residents to “freely, accurately, and honestly describe their teaching hospital environment in order to identify areas of improvement”\(^1\); and

Whereas, In 2009 the ACGME recommended an internal institutional form or other mechanism to give residents the opportunity to raise questions about and discuss educational and working conditions\(^1\); and

Whereas, Resident unions can provide a unified voice encouraging inter-specialty communication and engagement in hospital wide safety and quality improvement; and

Whereas, The Committee of Interns & Residents (the largest housestaff union composed of nearly 14,000 interns, residents, and fellows in California, Florida, Massachusetts, New York, New Mexico, and Washington D.C.) was formed in 1957 and aims to be “the national voice for physicians-in-training, uniting and empowering them to create a better and more just healthcare system for patients and healthcare workers and to improve training and quality of life for resident physicians, fellows, and their families”\(^2\); and

Whereas, There is still 87% of house staff not being represented by a union in this country; and

Whereas, Physicians as a whole could benefit from a union representing them and ensuring quality, safe, and evidenced based patient care; and

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\(^1\) Flavio Casoy, MD and Joanne Suh, MD, “Patients lose when resident physicians are afraid to unionize,” KevinMD.com, January 5, 2014, https://www.kevinmd.com/blog/2014/01/patients-lose-resident-physicians-afraid-unionize.html.

Whereas, Insurance companies partnering with various entities (drug store chains/retail clinics, urgent care centers) and even corporations to provide care options to patients has not been proven to be evidenced based, safe, or cost effective; and

Whereas, Physician membership, participation, and representation in organized medicine (including national organizations such as the American Medical Association and individual specialty societies) continues to be on the decline; and

Whereas, Physicians are increasingly becoming employed workers and 2016 was the year that marked the first time that physician practice owners are not the majority; and

Whereas, Various mergers mean uncertainty for how physicians would be able to practice; and

Whereas, Patients are often being given an incorrect diagnosis and management; and

Whereas, This has caused physicians to become more divided by specialty and further marginalized due to the lack of unity and bargaining power; and

Whereas, Patient care choices are being dictated by insurance companies and coverage; and

Whereas, Physicians as a cohort benefit from the work done by physician medical societies even if they are not dues paying members leaving less resources for organized medical physician groups to operate on; and

Whereas, Many physicians cite the lack of time, lack of interest, and lack of agreement with organized physician medical groups as the reason for not joining organized medicine; and

Whereas, There are regional unions such as the Union of American Physicians and Dentists that have been established; and

Whereas, A truly powerful physicians union will need to include all specialists; and

Whereas, Other countries have successful models for a physician union; and

Whereas, There is no national physician union representing physicians of all specialties in the U.S.; therefore be it

RESOLVED, That our American Medical Association study the feasibility of a national house-staff union to represent all interns, residents and fellows. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

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RELEVANT AMA POLICY

Resident Physicians, Unions and Organized Labor H-383.998
Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

Citation: CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17
Introduction

Whereas, The National Guideline Clearinghouse (NGC) was created in 1998 through a partnership between our AMA and American’s Health Insurance Plans (formerly known as the American Association of Health Plans); and

Whereas, Our AMA supports the wide dissemination of high-quality clinical guidelines after appropriate input by relevant physician organizations and interested physicians (Policy H-410.980); and

Whereas, Our AMA supported the creation and establishment of the NGC (Policy H-410.965); and

Whereas, The NGC acted as a database of clinical practice guidelines, allowing side-by-side comparison of two or more guidelines with information regarding development, implementation and use; and

Whereas, Funding for the NGC abruptly ended on July 16, 2018, resulting in the immediate closure of the NGC as well as its website without plans for replacement; and

Whereas, As the volume of clinical knowledge expands exponentially, clinical guidelines can help accelerate the adoption of new medical knowledge in clinical practice but can also thwart adoption of new medical knowledge when 100% compliance is required or when poorly constructed; and

Whereas, Before its closure, the NGC maintained 1400 clinical guidelines meeting strict methodological standards and received more than 200,000 visitors per month; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-410.965, “Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19
RELEVANT AMA POLICY

Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level
H-410.980

Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines.

(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.

(3) Clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.

(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.

(5) Clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors’ explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.

(6) Clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.

(7) Clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.

(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.

(9) Clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.

(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.


Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities H-410.965

(1) Our AMA continues to work with the Agency for Health Care Policy and Research and the American Association of Health Plans to advance the establishment of the National Guideline Clearinghouse and ensure the integrity of the Clearinghouse clinical practice guideline database.

(2) Our AMA provides the relevant national medical specialty societies the opportunity to review and have input into proposed performance indicators before implementing any pilot-testing of such indicators.

(3) Our AMA continues to work with national medical specialty societies and others in the development of standards for the appropriate collection, analysis, and reporting of valid and reliable physician-specific clinical performance and outcomes data.

(4) Our AMA continues to work with the Agency for Health Care Policy and Research and the American Association of Health Plans to advance the establishment of the National Guideline Clearinghouse.

Citation: (BOT Rep. 8, I-97; Appended: BOT Rep. 13, A-98; Reaffirmed: Res. 702, I-98; Modified: BOT Rep. 12, A-00; Modified: CSAPH Rep. 1, A-10
Resolved that our American Medical Association support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training (New HOD Policy); and be it further

Resolved that our AMA support that all programs provide financial advising to resident and fellows. (New HOD Policy)

Fiscal Note: Indeterminate.

References:
3. https://www.mededpublish.org/manuscripts/847/v1

RELEVANT AMA POLICY

Residents and Fellows’ Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians’ Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:

**RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS**

**Residents and fellows have a right to:**

**A. An education that fosters professional development, takes priority over service, and leads to independent practice.**

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

**B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.**

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

**C. Regular and timely feedback and evaluation based on valid assessments of resident performance.**

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

**D. A safe and supportive workplace with appropriate facilities.**

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

**E. Adequate compensation and benefits that provide for resident well-being and health.**

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the
conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Whereas, AMA Policy H-140.837, “Anti-Harassment Policy”, states that the AMA is “committed
to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are
conducting AMA business. This zero tolerance policy also applies to meetings of all AMA
sections, councils, committees, task forces, and other leadership entities (each, an “AMA
Entity”), as well as other AMA-sponsored events;” and

Whereas, The AMA Code of Medical Ethics 9.1.3, “Sexual Harassment in the Practice of
Medicine,” states that “physicians should promote and adhere to strict sexual harassment
policies in medical workplaces. Physicians who participate in grievance committees should be
broadly representative with respect to gender identity or sexual orientation, profession, and
employment status, have the power to enforce harassment policies, and be accessible to the
persons they are meant to serve;” and

Whereas, AMA Policy D-140.954, “Harassment Issues Within the AMA,” states that the AMA
“will immediately engage outside consultants to evaluate current processes and, as needed,
implement new processes for the evaluation and adjudication of sexual and non-sexual
harassment claims involving staff, members, or attendees with report back regarding said
processes and implementation at the 2019 Annual Meeting;” and

Whereas, AMA Policy H-525.998, “Women in Organized Medicine,” was adopted in 1981; and

the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures
should be updated by the AMA Women Physicians Congress, and forwarded to the House of
Delegates for approval, and include not only resources for training programs but also private
practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed
on the AMA Web site; and

Whereas, The fifth clause of AMA Policy H-525.998 has been implemented¹ and since been
superseded by current AMA policy; therefore be it
RESOLVED, That our AMA amend AMA Policy H-525.998, “Women in Organized Medicine,” by deletion to read as follows:

Our AMA:
(1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;
(2) supports the concept of increased tax benefits for working parents;
(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; and
(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and
(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site. (Modify HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

Reference

RELEVANT AMA POLICY

Women in Organized Medicine H-525.998
Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;
(2) supports the concept of increased tax benefits for working parents;
(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings;
(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and
(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.


E-9.1.3 Sexual Harassment in the Practice of Medicine
Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual’s work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working
relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship. Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II, IV, VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

Anti-Harassment Policy H-140.837

Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Anti-Harassment Policy

1. Reporting a complaint of harassment

Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.
Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.

[Editor’s note. Individuals wishing to register a complaint with AMA’s external vendor (Lighthouse Services, Inc.) may do so by calling 800-398-1496 or completing the online form at https://www.lighthouse-services.com/ama.]

Citation: BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18

**Harassment Issues Within the AMA D-140.954**

Our AMA will immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or attendees with report back regarding said processes and implementation at the 2019 Annual Meeting.

Citation: Emergency Res. 01, I-18
Whereas, A study published in the Canadian Medical Association Journal has shown that grant applications going through the peer review process submitted by women are scored lower than those submitted by men; and

Whereas, A study has shown that university professors in the basic sciences identified male applicants as superior to female applicants and deserving of higher compensation even though the application materials submitted were identical except for the names identifying them as male or female; and

Whereas, A study looking at the relationship between gender and the length and tone of letters of reference showed that female applicants were only half as likely as male applicants to receive an “excellent” letter versus a “good” letter, and that letters of reference for women applicants included substantially different adjectives, such as “diligent” and “hardworking,” as opposed to “brilliant” and “trailblazer” used to describe male applicants; and

Whereas, Our AMA has comprehensive policy on gender equity within the organization and has committed to presenting a report at the 2019 Annual Meeting; and

Whereas, Our AMA has some policy relating to gender equity in regards to physician compensation and advancement, but nothing specifically relating to gender equity in academic or commercial medical research; therefore be it

RESOLVED, That our American Medical Association advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19