

## **Reference Committee F**

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## REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-A-19

Subject: Annual Report

Presented by: Jack Resneck, Jr. MD, Chair

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

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- 1 The Consolidated Financial Statements for the years ended December 31, 2018 and 2017 and the
  - 2 Independent Auditor's report have been included in a separate booklet, titled "2018 Annual
  - 3 Report." This booklet is included in the Handbook mailing to members of the House of Delegates
  - 4 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)

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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:

Regular Members	\$ 420
Physicians in Their Second Year of Practice	\$ 315
Physicians in Military Service	\$ 280
Physicians in Their First Year of Practice	\$ 210
Semi-Retired Physicians	\$ 210
Fully Retired Physicians	\$ 84
Physicians in Residency Training	\$ 45
Medical Students	\$ 20

(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)

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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:
  - Exhibit professional, collegial behavior at all times

- 1       ○ Exercise consideration and respect in your speech and actions, including while making
- 2       formal presentations to attendees
- 3       ○ Be mindful of one's surroundings and of fellow participants
- 4       ○ Alert meeting Chair or meeting organizer of violations of the anti-harassment policy – even
- 5       if they seem inconsequential
- 6       • A statement about potential consequences for violation of the policy. For example: If a
- 7       participant engages in unacceptable behavior at an AMA meeting or event, AMA reserves the
- 8       right to take any action deemed appropriate based on the outcome of the incident
- 9       investigation(s). This action may include but is not limited to:
- 10      ○ Removing the violator from the AMA event or activity, without warning or refund;
- 11      ○ Prohibiting the violator from attending future AMA events or activities;
- 12      ○ Removing the violator from leadership or other roles in AMA activities;
- 13      ○ Prohibiting the violator from assuming a future leadership or other role in AMA activities;
- 14      ○ Revoking the violator's membership in the AMA, following the CEJA processes for taking
- 15      such an action;
- 16      ○ Notifying the violator's employer of the actions taken by AMA; and/or
- 17      ○ Notifying law enforcement.

18

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

23

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

27

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

30

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

36

37       Current best practices for implementation and enforcement include:

38

- 39       1. Ensuring awareness, acknowledgement and acceptance of the policy by meeting/event
- 40       participants
- 41       2. Simple and straightforward ways to report violations of the policy at the time of (or very close
- 42       in time to) the incident in question.
- 43       3. Independence and neutrality in investigation of violations of the policy.
- 44       4. Avoidance of even the appearance of conflicts of interest in decisions on consequences for
- 45       violations of the policy.
- 46       5. Assurance that all reports of violation and the outcomes of investigations will be reported to
- 47       the organization's counsel.
- 48       6. Assurance that reports, investigations, and outcomes will be kept confidential to the fullest
- 49       extent possible, consistent with usual business practices.

1 The consultants further recommend that the policy be amended to reflect the need for flexibility in  
2 procedures for receiving reports, investigating incidents, and making decisions on consequences.  
3 This flexibility is necessary because of the wide range of meetings and activities covered by the  
4 policy, including consideration of the purpose, size and duration of meetings and activities.

5  
6 Specifically, the consultants recommend adoption of the following operational guidelines for  
7 reporting, investigation, and enforcement of the policy.

8  
9 *Violation Reporting Procedures*

10  
11 In order to encourage individuals who are targets of harassment to report incidents, it is important  
12 to have a simple, straightforward, and easily publicized reporting mechanism. Ideally, reports  
13 should be taken and investigated by a single individual who is unlikely to face conflicts of interest  
14 in this role.

15  
16 The consultants recommend that the AMA bring in an independent consultant to act as the Conduct  
17 Liaison for larger meetings and events. This should be someone who is trained and experienced in  
18 handling incidents of harassment and bullying. The Conduct Liaison should be the primary point of  
19 contact for event participants to report violations of the policy, and responsible for any on-site  
20 investigations of those violations. The Conduct Liaison should provide recommendations for  
21 immediate action to the Event Chair or other senior designated AMA officer or representative  
22 involved in the AMA meeting in question, and should provide a formal report with  
23 recommendations for any further action to the Committee on Conduct at AMA Meetings and  
24 Events (CCAM, see below). All reported violations of the policy, and the outcomes of  
25 investigations by the Conduct Liaison, should be provided to the Office of General Counsel.

26  
27 For smaller meetings, the role of the Conduct Liaison may be assumed by an individual designated  
28 by the AMA Office of General Counsel and trained in advance of assuming such role, who may or  
29 may not be physically on-site at the meeting. If not on-site, the Conduct Liaison should be on-call.

30  
31 The consultants recommend retaining the requirement for a reporting hotline in addition to the  
32 Conduct Liaison, which will be an alternative source for meeting attendees to lodge complaints  
33 regarding conduct at meetings.

34  
35 *Investigation of Incidents*

36  
37 Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the  
38 event. This allows for immediate action at the event to protect the safety of event participants.  
39 When this is not possible, the Conduct Liaison may continue to investigate incidents following the  
40 event in order to provide recommendations for action to the CCAM.

41  
42 Investigations should consist of structured interviews with the person reporting the incident (the  
43 reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target  
44 identify, and the alleged violator.

45  
46 *Committee on Conduct at AMA Meetings and Events (CCAM)*

47  
48 The consultants recommend the establishment of a Committee on Conduct at AMA Meetings and  
49 Events (CCAM), to include 5-7 members who are nominated by the Office of General Counsel (or  
50 through a nomination process facilitated by the Office of General Counsel) and approved by the  
51 Board of Trustees. The consultants recommend that the CCAM should include one member of the



1 Women Physicians Section (WPS), and one member of the Council on Ethical and Judicial Affairs  
2 (CEJA). The remaining members may be appointed from AMA membership generally. Emphasis  
3 should be placed on maximizing the diversity of membership.  
4

5 The consultants recommend that the CCAM receive reports on all violations of the policy arising  
6 from any AMA meeting or event. When an incident is significant enough that it requires action  
7 beyond those taken on-site at the event, the CCAM reviews the incident reports, performs further  
8 investigation if needed, and makes recommendations regarding further commensurate sanctions to  
9 the Office of General Counsel and to the appropriate AMA body (e.g., meeting or event organizers,  
10 appropriate AMA staff, and/or CEJA).  
11

12 To prevent possible retaliatory action against CCAM members, all proceedings of the CCAM  
13 should be kept as confidential as practicable.  
14

## 15 CONCLUSION

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17 As noted above, consultants engaged by the AMA in furtherance of Policy D-140.954 have  
18 reviewed and evaluated the AMA's current Anti-Harassment Policy (Policy H-140.837) and  
19 confirmed that this existing policy includes many of the critical elements of an effective anti-  
20 harassment policy. However, while the current policy includes detailed procedures for reporting,  
21 investigation, and enforcement, several amendments to the policy are necessary to bring it fully in  
22 line with current best practices in implementation and enforcement. The consultants suggested that  
23 implementation of the existing procedures would be cumbersome and unlikely to bring about the  
24 desired outcome of making AMA meetings and events safer and more welcoming.  
25

26 The consultants have recommended modifications to ensure that the policy itself, and the  
27 procedures for reporting, investigation and enforcement of the policy, reflect current best practices.  
28 In particular, the consultants' recommended modifications are intended to ensure 1) simple ways to  
29 report violations, 2) prompt investigation and resolution of alleged violations, 3) independence and  
30 neutrality in investigation of violations, and the avoidance of conflicts of interest, and 4) flexibility  
31 in procedures for receiving reports, investigating incidents, and making decisions on consequences  
32 of the policy (recognizing the nature, number and varying size of AMA meetings conducted each  
33 year).  
34

35 The Board of Trustees has carefully considered the recommendations of the consultants, and  
36 believes that these recommendations are consistent with the goals and objectives of the AMA's  
37 current Anti-Harassment Policy and will result in significant improvements to help ensure that  
38 AMA meetings and events are safe and welcoming to all participants. The Board of Trustees also  
39 believes that these recommendations are responsive to comments and concerns expressed at the  
40 2018 Interim Meeting. Therefore, the Board of Trustees is recommending corresponding  
41 modifications to Policy H-140.837, "Anti-Harassment Policy," as set forth below.  
42

## 43 RECOMMENDATION

44

45 The Board of Trustees recommends the following, and that the remainder of this report be filed:  
46

- 47 1. That Policy D-140.954, "Harassment Issues Within the AMA," be rescinded as having been  
48 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.

~~a~~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

1 of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or  
2 JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such  
3 meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s)  
4 of such meeting or activity.

5  
6 Alternatively, violations may be reported using an AMA reporting hotline (telephone and  
7 online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will  
8 provide an option to report anonymously, in which case the name of the reporting party  
9 will be kept confidential by the vendor and not be released to the AMA. The vendor will  
10 advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

11  
12 These reporting mechanisms will be publicized to ensure awareness.

13  
14 3. Investigations

15  
16 All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and  
17 Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will  
18 be investigated by the Conduct Liaison. Each reported violation will be promptly and  
19 thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident  
20 investigations on-site during the event. This allows for immediate action at the event to  
21 protect the safety of event participants. When this is not possible, the Conduct Liaison may  
22 continue to investigate incidents following the event to provide recommendations for  
23 action to the CCAM. Investigations should consist of structured interviews with the person  
24 reporting the incident (the reporter), the person targeted (if they are not the reporter), any  
25 witnesses that the reporter or target identify, and the alleged violator.

26  
27 Based on this investigation, the Conduct Liaison will determine whether a violation of the  
28 Policy on Conduct at AMA Meetings and Events has occurred.

29  
30 All reported violations of the Policy on Conduct at AMA Meetings and Events, and the  
31 outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the  
32 AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison  
33 determines that a violation has occurred).

34  
35 4. Disciplinary Action

36  
37 If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA  
38 Meetings and Events has occurred, the Conduct Liaison may take immediate action to  
39 protect the safety of event participants, which may include having the violator removed  
40 from the AMA meeting, event or activity, without warning or refund.

41  
42 Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at  
43 AMA Meetings and Events has occurred, the Conduct Liaison shall report any such  
44 violation to the CCAM, together with recommendations as to whether additional  
45 commensurate disciplinary and/or corrective actions (beyond those taken on-site at the  
46 meeting, event or activity, if any) are appropriate.

47  
48 The CCAM will review all incident reports, perform further investigation (if needed) and  
49 recommend to the Office of General Counsel any additional commensurate disciplinary  
50 and/or corrective action, which may include but is not limited to the following:

- 1       ▪ Prohibiting the violator from attending future AMA events or activities;
- 2       ▪ Removing the violator from leadership or other roles in AMA activities;
- 3       ▪ Prohibiting the violator from assuming a leadership or other role in future AMA
- 4       activities;
- 5       ▪ Notifying the violator's employer and/or sponsoring organization of the actions taken
- 6       by AMA;
- 7       ▪ Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and
- 8       action;
- 9       ▪ Referral to law enforcement.

10  
11       The CCAM may, but is not required to, confer with the presiding officer(s) of applicable  
12       events activities in making its recommendations as to disciplinary and/or corrective  
13       actions. Consequence for policy violations will be commensurate with the nature of the  
14       violation(s).

15  
16       5. Confidentiality

17  
18       All proceedings of the CCAM should be kept as confidential as practicable. Reports,  
19       investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and  
20       Events will be kept confidential to the fullest extent possible, consistent with usual  
21       business practices.

22  
23       6. Assent to Policy

24  
25       As a condition of attending and participating in any meeting of the House of Delegates, or  
26       any council, section, or other AMA entities, such as the RVS Update Committee (RUC),  
27       CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or  
28       activity, each attendee will be required to acknowledge and accept (i) AMA policies  
29       concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA  
30       Meetings and Events and (ii) applicable adjudication and disciplinary processes for  
31       violations of such policies (including those implemented pursuant to these Operational  
32       Guidelines), and all attendees are expected to conduct themselves in accordance with these  
33       policies.

34  
35       Additionally, individuals elected or appointed to a leadership role in the AMA or its  
36       affiliates will be required to acknowledge and accept the Policy on Conduct at AMA  
37       Meetings and Events and these Operational Guidelines.

38  
39       1. Reporting a complaint of harassment

40  
41       ~~Any persons who believe they have experienced or witnessed conduct in violation of Anti-~~  
42       ~~Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated~~  
43       ~~functions should promptly notify the Speaker or Vice Speaker of the House or the AMA~~  
44       ~~Office of General Counsel.~~

45  
46       ~~Any persons who believe they have experienced or witnessed conduct in other activities~~  
47       ~~associated with the AMA (such as meetings of AMA councils, sections, the RVS Update~~  
48       ~~Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy~~  
49       ~~H-140.837 should promptly notify the presiding officer(s) of such AMA associated~~  
50       ~~meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.~~

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

## 6 7 2. Investigations

8  
9 ~~Investigations of harassment complaints will be conducted by AMA Human Resources.~~  
10 ~~Each complaint of harassment or retaliation shall be promptly and thoroughly investigated.~~  
11 ~~Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact~~  
12 ~~between the accuser and the accused during the pendency of an investigation and (b)~~  
13 ~~provide the accused an opportunity to respond to allegations. Based on its investigation,~~  
14 ~~AMA Human Resources will make a determination as to whether a violation of Anti-~~  
15 ~~Harassment Policy H 140.837 has occurred.~~

## 16 17 3. Disciplinary Action

18  
19 ~~If AMA Human Resources shall determine that a violation of Anti Harassment Policy H-~~  
20 ~~140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice~~  
21 ~~Speaker of the House or the presiding officer(s) of such other AMA associated meeting or~~  
22 ~~activity in which such violation occurred, as applicable, of such determination, (ii) refer the~~  
23 ~~matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or~~  
24 ~~corrective action, which may include but is not limited to expulsion from the relevant~~  
25 ~~AMA associated meetings or activities, and (iii) provide CEJA with appropriate training.~~

26  
27 ~~If a Delegate or Alternate Delegate is determined to have violated Anti Harassment Policy~~  
28 ~~H 140.837, CEJA shall determine disciplinary and/or corrective action in consultation with~~  
29 ~~the Speaker and Vice Speaker of the House.~~

30  
31 ~~If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT~~  
32 ~~Editorial Panel is determined to have violated Anti Harassment Policy H 140.837, CEJA~~  
33 ~~shall determine disciplinary and/or corrective action in consultation with the presiding~~  
34 ~~officer(s) of such activities.~~

35  
36 ~~If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the~~  
37 ~~matter to appropriate AMA management, and when appropriate, may suggest that the~~  
38 ~~complainant contact legal authorities.~~

## 39 40 4. Confidentiality

41  
42 ~~To the fullest extent possible, the AMA will keep complaints, investigations and~~  
43 ~~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

**"A Four-Part Series: Addressing Sexual Harassment in the #MeToo Era"** ("Best Practices for Investigating Allegations", "The Rights of the Alleged Harasser", "The Superstar Harasser—Is Anyone Really Too Big to Lose?" and "The Same Old Workplace Training Won't Cut It") *Corporate Compliance Insights*, February 8, March 28, May 4 and June 21, 2018

**"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

**"Gender Identity Discrimination Claims on the Rise at State and Federal Levels"** *The National Law Review*, March 3, 2016

### 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

**"Harassment in the Workplace, Part 2 - Community and Resources: Hearing Voices & Exploring Conversation Strategies"** American Institute of Architects Conference on Architecture 2018, June 23, 2018, New York, NY

**"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

**“Open Secrets and Missing Stairs: Sexual and Gender-Based Harassment at Scientific Meetings,”** available at <http://bit.ly/osmspdpf>

**“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.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-19

Subject: Data Used to Apportion Delegates

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

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

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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 constituent 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.

MEMBERSHIP		DUES	COUNTED IN
<u>YEAR</u>	<u>STATUS</u>	<u>PAYMENT</u>	<u>APPORTIONMENT</u>
Year 1	Pending	Pays for year 2	Counts for year 2
Year 2	Member	Does not renew	Counts for year 3
Year 3	Pending	Pays for year 4	Counts for year 4
Year 4	Member	Does not renew	Counts for year 5
Year 5	Pending	Pays for year 6	Counts for year 6

Inssofar 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.

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)~~
3. 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

Constituent Association	AMA members as of 31 Dec 2018	Apportionment 2019	AMA members including pending members	2019 hypothetical apportionment
<b>Total</b>	<b>250,253</b>	<b>280</b>	<b>263,061</b>	<b>290</b>
Alabama	3,062	4	3,206	4
Alaska	352	1	367	1
Arizona	4,271	5	4,424	5
Arkansas	2,021	3	2,090	3
California	22,429	23	23,548	24
Colorado	4,096	5	4,206	5
Connecticut	3,413	4	3,601	4
Delaware	668	1	690	1
District of Columbia	1,981	2	2,085	3
Florida	13,489	14	14,142	15
Georgia	4,874	5	5,170	6
Guam	25	1	28	1
Hawaii	1,078	2	1,119	2
Idaho	563	1	595	1
Illinois	11,069	12	11,580	12
Indiana	4,439	5	4,924	5
Iowa	2,151	3	2,212	3
Kansas <sup>1</sup>	1,903	2	1,990	2
Kentucky	3,228	4	3,376	4
Louisiana	4,024	5	5,571	6
Maine	1,337	2	1,367	2
Maryland	4,414	5	4,658	5
Massachusetts	12,321	13	12,546	13
Michigan	12,011	13	12,467	13
Minnesota	4,393	5	4,586	5
Mississippi	2,749	3	2,830	3
Missouri	4,846	5	5,123	6
Montana	679	1	704	1
Nebraska	1,640	2	1,727	2
Nevada	1,471	2	1,530	2
New Hampshire	877	1	918	1
New Jersey	7,074	8	7,455	8
New Mexico	1,285	2	1,345	2
New York	19,468	20	20,529	21
North Carolina	5,181	6	5,471	6
North Dakota	762	1	776	1
Ohio	10,593	11	11,066	12
Oklahoma	3,751	4	3,813	4
Oregon	1,902	2	2,015	3
Pennsylvania	13,213	14	13,886	14
Puerto Rico	1,399	2	1,495	2
Rhode Island	1,018	2	1,072	2
South Carolina	4,572	5	4,694	5
South Dakota	963	1	997	1
Tennessee	4,744	5	4,943	5
Texas	18,002	19	18,735	19

Constituent Association	AMA members as of 31 Dec 2018	Apportionment 2019	AMA members including pending members	2019 hypothetical apportionment
Utah	1,668	2	1,760	2
Vermont	416	1	444	1
Virgin Islands	37	1	40	1
Virginia	7,111	8	7,360	8
Washington	3,888	4	4,087	5
West Virginia	1,831	2	1,944	2
Wisconsin	4,556	5	4,800	5
Wyoming	202	1	205	1
APO/FPO	743	-	749	-

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).



## APPENDIX 2

### Current AMA Policy and Bylaws

#### 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.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-A-19

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)

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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

1 practices vary widely. Some distributors elect to absorb the cost of CPT royalties paid to the AMA,  
2 or embed the cost into the cost of their product(s), while others choose to directly pass the cost  
3 through to their customers. Some distributors license their software (and in turn CPT) based on  
4 aggregate user counts, do not track the identities of specific users, and as a result, are unaware of an  
5 individual physician's usage of their product or that physician's membership status with the AMA.  
6

7 As for CPT licensees who contract directly with the AMA (rather than through a distributor), most  
8 are large or mid-sized health systems, hospitals or practices. As mentioned above, the AMA does  
9 not receive information identifying specific users covered under the CPT license and thus is not  
10 able to confirm which users are physicians and whether any such physician user is an AMA  
11 member. We note that small practices with 25 or fewer CPT users are currently eligible for CPT  
12 royalty discounts between 13 and 22% when an AMA physician member purchases the license  
13 directly from the AMA, as AMA physician membership can be confirmed in this limited situation.  
14 The discount is applied to the entire license, not just the pro rata portion related to the individual  
15 physician member.  
16

## 17 DISCUSSION

18

19 The CPT code set is a mission-driven product, which means that its royalties, like those from  
20 JAMA and other AMA assets, are used to carry out the mission to promote the art and science of  
21 medicine and the betterment of public health, to the benefit of all physicians and patients.  
22

23 Development of a new CPT licensing and distribution process to administer a membership-based  
24 discount is at best impractical, requiring a complete reinvention of the AMA's licensing and  
25 distribution model, renegotiation of hundreds of contracts, and the introduction of cumbersome  
26 business processes that AMA's distributors are unlikely to accept. It would also require high  
27 volume and high frequency exchange of sensitive data and a large data reconciliation process. This  
28 approach would be inefficient, burdensome and costly for the AMA, the AMA's distributors and  
29 the distributors' licensees. Even if these significant changes were undertaken, it is unclear that  
30 savings would be delivered to AMA members, as distributors (often commercial companies) have  
31 different interests than membership organizations.  
32

## 33 CONCLUSION

34

35 The AMA enhances its ability to achieve its mission by managing its assets in a fiscally prudent  
36 manner. Expanding CPT discounts beyond direct licensees would present significant policy,  
37 operational and contractual challenges that would divert resources from other important endeavors  
38 and result in unnecessary cost to the AMA. It is also very likely that the benefits of these discounts  
39 would accrue to distributors or licensee organizations rather than to AMA member physicians.  
40

## 41 RECOMMENDATION

42

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

Fiscal note: None

REPORT 27 OF THE BOARD OF TRUSTEES (A-19)  
Advancing Gender Equity in Medicine  
(Reference Committee F)

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)

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### 1 INTRODUCTION

2  
3 American Medical Association (AMA) Policy D-65.989 (1), “Advancing Gender Equity in  
4 Medicine,” directs our AMA to “draft and disseminate a report detailing its positions and  
5 recommendations for gender equity in medicine, including clarifying principles for state and  
6 specialty societies, academic medical centers and other entities that employ physicians, to be  
7 submitted to the House for consideration at the 2019 Annual Meeting.” This report responds to this  
8 directive.  
9

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

19 This report: 1) describes issues associated with gender bias; 2) summarizes AMA positions and  
20 recommendations to promote gender equity in medicine; and 3) provides clarifying principles for  
21 state and specialty societies, academic medical centers and other entities that employ physicians.  
22

### 23 BACKGROUND

24  
25 Gender disparities in advancement and income are pervasive in medical practice settings,  
26 specialties, and positions. Significant differences in salary exist after accounting for age,  
27 experience, specialty, faculty rank, and measures of research productivity and clinical revenue.  
28 Advancement for women physicians has been slower than would be anticipated despite the  
29 growing number of women in medicine.  
30

31 According to the U.S. Bureau of Labor Statistics, women earned about 82 percent of what men  
32 earned among full-time workers in all industries.<sup>1</sup> The gender pay disparity is indicative of “how  
33 far our nation still has to go to ensure that women can participate fully and equally in our  
34 economy,” according to a report from the National Partnership for Women and Families.<sup>2</sup>  
35

36 Gender-based disparities in income and advancement are also prevalent in medicine. The 2018  
37 Medscape Physician Compensation Report noted considerable gaps in pay, with female physicians

1 in primary care earning nearly 18 percent less (\$36,000) than their male counterparts. Among  
2 physicians the pay disparity was more pronounced with females earning 36.1 percent less  
3 (\$95,000) than their male counterparts. This income disparity was consistent across all medical  
4 specialties.<sup>3</sup>

5  
6 Ly, Seabury, and Jena conducted an analysis on income disparities among physicians, stratified by  
7 race and gender. Study results identified a considerable pay gap among black and white male  
8 physicians. The study also found that the income of black and white female physicians is “similar,  
9 but significantly lower than the incomes of male physicians.”<sup>4</sup>

10  
11 In the United States, women represent more than one third (35.2%) of the active physician  
12 workforce,<sup>5</sup> nearly half (45.6%) of all physicians-in-training<sup>6</sup> and more than half (50.7%)<sup>7</sup> of all  
13 entering medical students in MD-granting medical schools. Although the number of women  
14 entering the medical field has steadily increased, their proportion of leadership positions continues  
15 to be small. In a 2015 survey, women physicians (n = 3,285) identified the leadership positions  
16 they held as: medical director (35%), practice owner (23%), practice partner (13%), CEO (3%), and  
17 CMO (3%).<sup>8</sup>

#### 18 19 *Gender Disparities in Academic Medicine*

20  
21 A study of 10,241 physicians in 24 U.S. public medical schools found the annual salaries of female  
22 physicians were lower than those of male physicians, even after adjusting for “age, experience,  
23 specialty, faculty rank, and measures of research productivity and clinical revenue.” This study  
24 noted that “sex differences in salary were present at all faculty ranks and were largest among full  
25 professors.” The average salary difference among male and female full professors was \$33,620.  
26 Further, the adjusted salaries of female full professors (averaging \$250,971) were comparable to  
27 those of male associate professors (averaging \$247,212).<sup>9</sup>

28  
29 Another study compared faculty income at 24 medical schools over a 17-year period and found that  
30 female physicians in academic medicine earned on average \$20,000 less per year than their male  
31 counterparts. That is to say, female physicians earned 90 cents for every dollar made by male  
32 physicians.<sup>10</sup> These findings adjusted for factors such as specialty, experience, and faculty rank.

33  
34 In addition to salary disparities, leadership disparities exist as well, with female physicians  
35 underrepresented in the higher ranks of medical school faculty. Although women accounted for  
36 41.3 percent of full-time medical school faculty in 2018, they made up only 25 percent of tenured  
37 faculty (of all ranks) and only 24.6 percent of full professors and 37.5 percent of associate  
38 professors.<sup>11, 12</sup> Female physicians were also underrepresented in leadership positions at medical  
39 schools. Eighteen percent of department chairs (permanent and interim)<sup>13</sup> and eighteen percent of  
40 deans (permanent and interim) were women.<sup>14</sup>

#### 41 42 DISCUSSION

43  
44 Despite the increasing number of women physicians, gender-based differences in compensation  
45 and advancement exist in the medical profession. Researchers have cited factors such as specialty,  
46 experience, productivity, and work status as the reasons for these disparities. However, study  
47 results indicate that gender disparities persist even when controlling for age, specialty and practice  
48 characteristics. The following issues, which are often associated with gender inequities in  
49 medicine, have been highlighted for discussion.



## *Gender Bias and Discrimination*

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.<sup>15</sup>

Adesoye, Mangurian, Choo, et al. conducted a study of physician mothers to assess their experiences with work place 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.<sup>16</sup>

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.<sup>17</sup> 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).<sup>18</sup>

## *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.”<sup>19</sup> 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.<sup>20</sup> 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.<sup>21</sup>

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

1 schools found that men were more likely to be mentored by someone from senior executive level  
2 positions (62% of men compared to 52% of women). After a two-year follow-up, it was found that  
3 men earned \$9,260 more than women annually and were promoted 15 percent more often.<sup>22</sup>

#### 4 5 *Work-Life Balance*

6  
7 Many female physicians report work-life balance as a significant concern that may influence their  
8 career choices. This may be reflected in the disproportionate number of women physicians who  
9 choose part-time or reduced work hours to balance professional and personal life. In a recent  
10 survey, 92 percent of young physicians noted that they believe it is important to have a balance  
11 between work and personal responsibilities. However, only 65 percent felt they have achieved  
12 work-life balance.<sup>23</sup>

13  
14 While male physicians are increasingly expressing interest in flexible family leave and work  
15 options, female physicians continue to bear primary responsibility for caregiving and may face  
16 more challenges in aligning their career goals with family needs. Nearly a quarter (22%) of female  
17 physicians reported working part-time compared to twelve percent of male physicians.<sup>24</sup> Further, a  
18 2017 study found that hours worked by women physicians with children remained statistically  
19 lower when compared to women physicians without children.<sup>25</sup>

20  
21 When professionals reach their mid-40s, many of them assume responsibility for eldercare, or  
22 providing care for older relatives. According to a 2017 Bureau of Labor Statistics report, more than  
23 twenty percent (21.4%) of adults between the ages of 45-54 and nearly a quarter (24.3%) of adults  
24 between the ages of 55-64 provide care for an older relative. This same report notes that there are  
25 currently 41.3 million adults that provide unpaid eldercare and the majority are women (56%).<sup>26</sup>  
26 Although flexible work options (e.g., part-time work, re-entry, etc.) are intended to balance  
27 professional and personal responsibilities, there is also an impact on income and earning potential.  
28 Additional accommodations, such as flexible scheduling time and re-entry assistance programs,  
29 need to be offered beyond parental and family leave.

#### 30 31 *Increased Risk of Burnout*

32  
33 Burnout among physicians has been associated with adverse quality outcomes, diminished patient  
34 satisfaction, increased job dissatisfaction, and reduction of work effort. More than half of U.S.  
35 physicians are experiencing symptoms of burnout and the prevalence of burnout in physicians is  
36 nearly two times greater than other professions. Similarly, the prevalence of burnout and  
37 depression among medical students and residents is higher than individuals of similar age.<sup>27</sup>

38  
39 Findings from a survey of more than 15,000 physicians from 29 specialties noted that 50 percent of  
40 female physicians reported burnout, compared with 39 percent of their male peers.<sup>28</sup> Many factors  
41 contribute to burnout, including administrative burdens, challenges in working with electronic  
42 health records, discrimination, lack of respect, and maintaining work-life balance.

43  
44 In addition, the conflict between professional and personal responsibilities has been associated with  
45 increasing burnout odds by 200 to 250 percent.<sup>29</sup> Women are often disproportionately responsible  
46 for childcare and family responsibilities. Further, maternal discrimination was associated with  
47 higher self-reported burnout (45.9% burnout in those with maternal discrimination compared to  
48 33.9% burnout in those without).<sup>30</sup> Ultimately, it has been noted that “less pay combined with  
49 physician burnout might lead to more female physicians leaving the profession.”<sup>31</sup>

## 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 policies 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;

- 1 6. declares that compensation should be equitable and based on demonstrated  
2 competencies/expertise and not based on personal characteristics;  
3
- 4 7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-  
5 entry, and contract negotiations as options for physicians to support work-life balance;  
6
- 7 8. affirms that transparency in pay scale and promotion criteria is necessary to promote  
8 gender equity, and as such academic medical centers, medical schools, hospitals, group  
9 practices and other physician employers should conduct periodic reviews of compensation  
10 and promotion rates by gender and evaluate protocols for advancement to determine  
11 whether the criteria are discriminatory; and  
12
- 13 9. affirms that medical schools, institutions and professional associations should provide  
14 training on leadership development, contract and salary negotiations and career  
15 advancement strategies that include an analysis of the influence of gender in these skill  
16 areas. (New HOD Policy)  
17
- 18 2. That our AMA rescind the following policies, as they have been incorporated into the  
19 “Principles for Advancing Gender Equity in Medicine”:  
20
- 21 a. D-200.981, “Gender Disparities in Physician Income and Advancement”  
22 b. H-525.992, “Women in Medicine”  
23 c. H-65.968, “Equal Opportunity” (Rescind HOD Policy)  
24
- 25 3. That our AMA rescind AMA Policy D-65.989 (1), “Advancing Gender Equity in Medicine,” as  
26 this report has fulfilled the request for information on positions and recommendations  
27 regarding gender equity in medicine, including the development of clarifying principles.  
28 (Rescind HOD Policy)  
29
- 30 4. That our AMA encourage state and specialty societies, academic medical centers, medical  
31 schools, hospitals, group practices and other physician employers to adopt the AMA Principles  
32 for Advancing Gender Equity in Medicine. (Directive to Take Action)  
33
- 34 5. That our AMA encourage academic medical centers, medical schools, hospitals, group  
35 practices and other physician employers to: (a) adopt policies that prohibit harassment,  
36 discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe  
37 disciplinary and/or corrective action should violation of such policies occur. (Directive to Take  
38 Action)  
39
- 40 6. That our AMA, modify Policy D-65.989, “Advancing Gender Equity in Medicine,” and  
41 continue to: (a) advocate for institutional, departmental and practice policies that promote  
42 transparency in defining the criteria for initial and subsequent physician compensation; (b)  
43 advocate for pay structures based on objective, gender-neutral ~~objective~~ criteria; (c) encourage  
44 a specified approach, sufficient to identify gender disparity, to oversight of compensation  
45 models, metrics, and actual total compensation for all employed physicians; and (d) advocate  
46 for training to identify and mitigate implicit bias in compensation determination for those in  
47 positions to determine salary and bonuses, with a focus on how subtle differences in the further  
48 evaluation of physicians of different genders may impede compensation and career  
49 advancement. (Modify HOD Policy)

- 1 7. That our AMA amend AMA Policy G-600.035, “The Demographics of the House of  
2 Delegates,” to read as follows:  
3  
4 a. A report on the demographics of our AMA House of Delegates will be issued  
5 annually and include information regarding age, gender, race/ethnicity, education,  
6 life stage, present employment, and self-designated specialty.  
7  
8 b. As one means of encouraging greater awareness and responsiveness to diversity, our  
9 AMA will prepare and distribute a state-by-state demographic analysis of the House  
10 of Delegates, with comparisons to the physician population and to our AMA  
11 physician membership every other year.  
12  
13 c. Future reports on the demographic characteristics of the House of Delegates should,  
14 whenever possible, ~~will~~ identify and include information on successful initiatives and  
15 best practices to promote diversity within, ~~particularly by age,~~ state and specialty  
16 society delegations. (Modify Current HOD Policy)

Fiscal Note: Less than \$5,000

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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.

Proposed language for adoption	Original language
Our AMA: 1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender)	Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; <a href="#">H-65.968</a>
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;	(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; <a href="#">H-65.968</a>
	<del>(3) affirms the concept of equal rights for men and women;</del> <a href="#">H-65.968</a>
3. endorses the principle of equal opportunity of employment and practice in the medical field;	(4) endorses the principle of equal opportunity of employment and practice in the medical field. <a href="#">H-65.968</a>
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;	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. <a href="#">H-525.992</a>
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 comparable work at each career stage, demonstrated competencies/expertise and not based on personal characteristics;	--
	<del>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;</del> <a href="#">D-200.981</a>
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;	(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; <a href="#">D-200.981</a>



<p>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</p>	<p>(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; <a href="#">D-200.981</a></p>
	<p><del>(4) will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession; <a href="#">D-200.981</a></del></p>
<p>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.</p>	<p>and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit. <a href="#">D-200.981</a></p>

## 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

Policy Language	Status
<p>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.</p>	<p>AMA PolicyFinder was updated to include <a href="#">Advancing Gender Equity in Medicine D-65.989</a>.</p>
<p>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.</p>	<p>Programming will be developed for future AMA meetings.</p>
<p>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.</p>	<p>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.</p>

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.	An evaluation of gender/demographic equity for pay practices in AMA's internal workforce is underway.
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REPORT OF THE HOUSE OF DELEGATES COMMITTEE  
ON THE COMPENSATION OF THE OFFICERS

Report A-19

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Marta J. Van Beek, MD, Chair

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

---

1 This report by the Committee at the 2019 Annual Meeting presents one recommendation.

2  
3 BACKGROUND

4  
5 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on  
6 Trustee Compensation, currently named the Committee on Compensation of the Officers, (“the  
7 Committee”). The Officers are defined in the American Medical Association’s (AMA) Constitution  
8 and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V  
9 refers simply to “Officer,” which includes all 21 members of the Board among whom are President,  
10 President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the  
11 HOD, collectively referred to in this report as Officers). The composition, appointment, tenure,  
12 vacancy process and reporting requirements for the Committee are covered under the AMA  
13 Bylaws. Bylaws 2.13.4.5 provides:

14  
15 The Committee shall present an annual report to the House of Delegates recommending the  
16 level of total compensation for the Officers for the following year. The recommendations of the  
17 report may be adopted, not adopted or referred back to the Committee, and may be amended  
18 for clarification only with the concurrence of the Committee.

19  
20 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s  
21 definition of total compensation in which was added to the Glossary of the AMA Constitution  
22 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an  
23 individual or work performance including: (a) all forms of money or cash compensation;  
24 (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

25  
26 Since the inception of this Committee, its reports document the process the Committee follows to  
27 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective  
28 compensation practices as derived from research and use of independent external consultants,  
29 expert in Board Compensation. Reports beginning in December 2002 documented the principles  
30 the Committee followed in creating its recommendations for Officer compensation.

31  
32 At A-08, the HOD approved changes that simplified compensation practices with increased  
33 transparency and consistency. At A-10, Reference Committee F requested that this Committee  
34 recommend that the HOD affirm a codification of the current compensation principle, which  
35 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base  
36 its recommendations for Officer compensation on the principle of the value of the work performed,  
37 consistent with IRS guidance and best practices as recommended by the Committee’s external  
38 independent consultant, who is expert in Board compensation.

1 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation  
2 with that of all other Officers (excluding Presidents and Chair) because these positions perform  
3 comparable work.

4  
5 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves  
6 Group, to update his 2007 research by providing the Committee with comprehensive advice and  
7 counsel on Officer compensation. The updated compensation structure was presented and approved  
8 by the HOD at I-11 with an effective date of July 1, 2012.

9  
10 The Committee's I-13 report recommended and the HOD approved the Committee's  
11 recommendation to provide a travel allowance for each President to be used for upgrades because  
12 of the significant volume of travel in representing our AMA.

13  
14 At I-16, based on the result of a comprehensive compensation review conducted by Ms. Becky  
15 Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, the Committee  
16 recommended and the HOD approved modest increased to the Governance Honorarium and Per  
17 Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-  
18 17's report, approved by the HOD, modified the Governance Honorarium and Per Diem definition  
19 so that Internal Representation, in excess of eleven days, receives a per diem.

20  
21 At A-18, based on a compensation review focused on the Presidents' and Chairs' compensation,  
22 the Committee recommended and the House approved a modest increase to their Honoraria, the  
23 first increase in ten years.

## 24 25 METHODOLOGY

26  
27 At I-18, this Committee recommended and the House approved an Annual Health Insurance  
28 Stipend (Stipend) for the President, President-Elect and the Immediate Past President when  
29 replacement health insurance is needed because he/she loses health insurance coverage at their  
30 practice, university or hospital (collectively referred to as "Employer") when they reduce their  
31 work schedule to fulfill their responsibilities as President, President-Elect or Immediate Past  
32 President.

33  
34 The amount of the Stipend was based on 70% of the then current Gold Plan premium in the  
35 President(s) state of residence for each covered family member. The Stipend ended when a  
36 President, President-Elect or Immediate Past President became Medicare eligible during their term  
37 in office because the Stipend was based on the President's need for health insurance which was met  
38 via Medicare.

39  
40 The Committee heard testimony at Reference Committee F in support of the Stipend, however  
41 there were questions about the Stipend ending for the President's covered family members when  
42 the President became Medicare eligible while in office. The Committee completed additional  
43 research and concluded that revisions to the definitions were warranted because the President(s)  
44 covered family members also needed replacement health insurance when the President(s) lost  
45 insurance from his/her Employer upon reducing their work schedule to fulfill AMA  
46 responsibilities.

47  
48 The Committee also noted that for clarity, the definition of the Stipend replaces "age 65" with  
49 "Medicare eligibility."

1 FINDINGS

2  
3 The Committee notes that the President-Elect, President and Immediate Past President  
4 responsibilities require a significant time commitment in supporting our AMA in governance and  
5 representation functions. Our A-18 report noted that this level of responsibility results in a time  
6 commitment well above that required by other not-for-profit boards. The level of commitment  
7 needed in supporting our AMA may necessitate a President reduce his/her work schedule with  
8 his/her Employer to a part-time status which may result in a President and his/her covered family  
9 members losing their eligibility for Employer's health insurance coverage.

10  
11 This Committee considers health insurance a necessity. At I-18 the Committee recommended and  
12 the House approved a Stipend for the President and his/her family when they lose their Employer's  
13 health insurance. This Committee recommends amending the definition of eligibility so that  
14 President(s) who already have health insurance coverage through Medicare when elected will not  
15 be eligible for the Stipend for themselves or family members. Additionally, this Committee  
16 recommends amending the eligibility definition so that if a President becomes Medicare eligible  
17 while in office, the President will be expected to enroll in Medicare and the Stipend will continue  
18 to cover family members who are not Medicare eligible. The amount of the Stipend will be  
19 adjusted accordingly. The Stipend would be reported as taxable income to the President(s).

20  
21 RECOMMENDATIONS

22  
23 The Committee on Compensation of the Officers recommends the following recommendations be  
24 adopted and the remainder of this report filed:

- 25  
26 1. That Policy D-605.990 be appended by a new section XXIII as follows:

27  
28 Annual Health Insurance Stipend ("Stipend")

29 The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate  
30 the President, President-Elect, and Immediate Past President when the President(s) lose(s)  
31 his/her Employer provided medical insurance coverage. President(s) who lose his/her  
32 Employer insurance will substantiate his/her eligibility for the Stipend by written notice to the  
33 Board Chair detailing the effective date of the loss of coverage and listing covered family  
34 members. The President receiving the Stipend will have the sole discretion to determine the  
35 appropriate health insurance for himself/herself and the family members; however, the Stipend  
36 will be calculated based on 70% of the then current Gold Plan premium for his/her state/county  
37 of residence.

38  
39 Should a President become Medicare eligible during his/her term(s), the Stipend will end for  
40 the President the month Medicare coverage begins. If the President has covered family  
41 members who are not Medicare eligible, the amount of the Stipend will be adjusted to cover  
42 only those family members until they become Medicare eligible. As family members become  
43 Medicare eligible, the President is expected to provide written notice of the event to the Board  
44 Chair and the Stipend will be adjusted accordingly the month Medicare coverage begins.

45  
46 In any case, the Stipend will end the sooner the President(s) obtains other health insurance  
47 coverage or the month following the end of his/her term as Immediate Past President.

48  
49 Should a President have health insurance coverage through Medicare when elected, he/she will  
50 not be eligible for the Stipend for themselves or family members.

1 The amount of the Stipend will be 70% of the then current Gold Plan premium in the  
2 President(s) state/county of residence for each covered family member. If there are multiple  
3 Gold Plans in the state/county, the Stipend will be based on the average of the then current  
4 Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year  
5 based on then Gold Plan premiums and covered family members.

6  
7 The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable  
8 income for the President each calendar year and will be included in this Committee's annual  
9 report to the House which documents compensation paid to Officers and the IRS reported  
10 taxable value of benefits, perquisites, services, and in-kind payments.

- 11  
12 2. Except as noted above, there will be no other changes to the Officers compensation for the  
13 period beginning July 1, 2019. (Directive to Take Action)

Fiscal Note: The maximum annual stipend is estimated at \$87,000. This is based on 70% of the highest 2018 Gold Plan Premium based on current Board demographics and assumes all 3 Presidents and spouses/partners would receive the stipend in the same year.



## APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President	\$284,960
President-Elect	\$284,960
Chair	\$280,280
Chair-Elect	\$207,480

### Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

### Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,300 per day.

### Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or \$650.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601  
(A-19)

Introduced by: Indiana

Subject: AMA Policy Statement with Editorials

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

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1 Whereas, Freedom of speech is essential and all sides of an issue deserve to be discussed;  
2 and  
3

4 Whereas, Our AMA has good policy on most medical issues; and  
5

6 Whereas, The Aug. 22-29, 2017, *JAMA* published an editorial on Maintenance of Certification  
7 contrary to AMA policy; therefore be it  
8

9 RESOLVED, That our American Medical Association include a policy statement after all  
10 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.

Res. 294, A-90 BOT Rep. G, A-91 BOT Rep. VV, I-92 BOT Rep. PP, A-93 Res. 622, I-96 Res. 612, A-97 Reaffirmed: Sunset Report and Appended: BOT Rep. 22, I-00 Consolidated: CLRPD Rep. 3, I-01 Appended: BOT Rep. 32, A-04 Modified: CCB/CLRPD Rep. 3, A-12 Modified: Speakers Rep., A-15

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602  
(A-19)

Introduced by: Susan R. Bailey, MD, Delegate; and Bruce A. Scott, MD, Delegate

Subject: Expectations for Behavior at House of Delegates Meetings

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

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1 Whereas, Our American Medical Association House of Delegates (HOD) has adopted  
2 Policy H-140.837 declaring that any type of harassment of AMA staff, fellow delegates or  
3 others by members of the House of Delegates or other attendees at or in connection with  
4 HOD meetings and other AMA-sponsored meetings or events is prohibited conduct and is  
5 not tolerated; and  
6

7 Whereas, Our AMA HOD has also adopted Policy D-140.954 calling for an external  
8 evaluation of the anti-harassment processes set forth in Policy H-140.837 with a report  
9 back at this meeting; and  
10

11 Whereas, Harassment consists of unwelcome conduct whether verbal, physical or visual  
12 that denigrates or shows hostility or aversion toward an individual because of his/her race,  
13 color, religion, sex, sexual orientation, gender identity, national origin, age, disability,  
14 marital status, citizenship or other protected group status, and that: (1) has the purpose or  
15 effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or  
16 effect of unreasonably interfering with an individual's participation in meetings or  
17 proceedings of the HOD or any other AMA-sponsored meeting or event; or (3) otherwise  
18 adversely affects an individual's participation in such meetings or proceedings or, in the  
19 case of AMA staff, such individual's employment opportunities or tangible job benefits;  
20 and  
21

22 Whereas, Harassing conduct includes, but is not limited to epithets, slurs or negative  
23 stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written,  
24 electronic, or graphic material that denigrates or shows hostility or aversion toward an  
25 individual or group and that is placed on walls or elsewhere on the AMA's premises or at  
26 the site of any AMA meeting or circulated in connection with any AMA meeting; and  
27

28 Whereas, Our Rules and Credentials Committee proposes and our AMA HOD adopts a  
29 rule at every meeting calling for respectful behavior at all times; and  
30

31 Whereas, Our AMA HOD has collectively recognized the odious nature of harassing  
32 behaviors in its prior actions; and  
33

34 Whereas, Every delegate and alternate delegate should acknowledge their role in  
35 preventing harassment at AMA meetings, but particularly at our own HOD meetings, as  
36 part of the meeting registration process; therefore be it

- 1 RESOLVED, That every AMA HOD delegate and alternate delegate shall, as a condition  
2 to receiving their credentials for any AMA HOD meeting, acknowledge and accept during  
3 the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA  
4 HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of  
5 such policies (New HOD Policy); and be it further  
6  
7 RESOLVED, That any AMA HOD delegate or alternate delegate who knowingly fails to  
8 acknowledge and accept during the AMA HOD meeting registration process (i) AMA  
9 policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and  
10 disciplinary processes for violations of such policies shall not be credentialed as a  
11 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603  
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,  
Rhode Island, Vermont

Subject: Creation of an AMA Election Reform Committee

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

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1 Whereas, Members of our AMA House of Delegates cherish our democratic process; and

2  
3 Whereas, Our current election and voting process for AMA officers and council positions  
4 consumes a lot of time and financial resources; and

5  
6 Whereas, Election reform would allow for more time for policy and debate during HOD sessions;  
7 and

8  
9 Whereas, Cost barriers are often an impediment to candidate elections; and

10  
11 Whereas, There are significant technological advances that could allow for an expedited  
12 process of elections and debate; therefore be it

13  
14 RESOLVED, That our American Medical Association appoint a House of Delegates Election  
15 Reform Committee to examine ways to expedite and streamline the current election and voting  
16 process for AMA officers and council positions (Directive to Take Action); and be it further

17  
18 RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following  
19 options:

- 20  
21 - The creation of an interactive election web page;  
22 - Candidate video submissions submitted in advance for HOD members to view;  
23 - Eliminate all speeches and concession speeches during HOD deliberations, with the  
24 exception of the President-Elect, Speaker and Board of Trustee positions;  
25 - Move elections earlier to the Sunday or Monday of the meeting;  
26 - Conduct voting from HOD seats (Directive to Take Action); and be it further

27  
28 RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns  
29 (Directive to Take Action); and be it further

30  
31 RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019  
32 Interim Meeting with a list of recommendations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is between \$15K-\$25K.

Received: 04/12/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604  
(A-19)

Introduced by: Illinois

Subject: Engage and Collaborate with The Joint Commission

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

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 measureable 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:

1. Phillips DM. JCAHO Pain Management Standards are Unveiled. JAMA. 2000; 284(4):428-429.
2. Flodgren G, Goncalves-Bradley DC, Pomey MP. External inspection of compliance with standards for improved healthcare outcomes. Cochrane Database Syst Rev. 2016, Dec 2; 12. CD008992; doi:10.1002/14651858.CD008992.pub3.
3. Brubakk K, Vist GE, Bukholm G, et al. A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. BMC Health Services Research. 2015; 15:280-290.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605  
(A-19)

Introduced by: New York

Subject: State Societies and the AMA Litigation Center

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

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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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606  
(A-19)

Introduced by: Resident and Fellow Section

Subject: Investigation into Residents, Fellows, and Physician Unions

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

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Whereas, Approximately 13% residents and fellows are part of formal unions<sup>1</sup>; and

Whereas, The ACGME introduced the Clinical Learning Environment Review (CLER) program in 2012 where teaching hospitals are visited every 18 months<sup>1</sup>; 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<sup>1</sup>; 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”<sup>1</sup>; 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<sup>1</sup>; 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”<sup>2</sup>; 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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<sup>1</sup> 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>.

<sup>2</sup> Committee of Interns and Residents, <https://www.cirseiu.org>.

1 Whereas, Insurance companies partnering with various entities (drug store chains/retail clinics,  
2 urgent care centers) and even corporations to provide care options to patients has not been  
3 proven to be evidenced based, safe, or cost effective<sup>3</sup>; and  
4

5 Whereas, Physician membership, participation, and representation in organized medicine  
6 (including national organizations such as the American Medical Association and individual  
7 specialty societies) continues to be on the decline; and  
8

9 Whereas, Physicians are increasingly becoming employed workers and 2016 was the year that  
10 marked the first time that physician practice owners are not the majority<sup>4</sup>; and  
11

12 Whereas, Various mergers mean uncertainty for how physicians would be able to practice; and  
13

14 Whereas, Patients are often being given an incorrect diagnosis and management; and  
15

16 Whereas, This has caused physicians to become more divided by specialty and further  
17 marginalized due to the lack of unity and bargaining power; and  
18

19 Whereas, Patient care choices are being dictated by insurance companies and coverage; and  
20

21 Whereas, Physicians as a cohort benefit from the work done by physician medical societies  
22 even if they are not dues paying members leaving less resources for organized medical  
23 physician groups to operate on; and  
24

25 Whereas, Many physicians cite the lack of time, lack of interest, and lack of agreement with  
26 organized physician medical groups as the reason for not joining organized medicine; and  
27

28 Whereas, There are regional unions such as the Union of American Physicians and Dentists  
29 that have been established<sup>5,6</sup>; and  
30

31 Whereas, A truly powerful physicians union will need to include all specialists<sup>7</sup>; and  
32

33 Whereas, Other countries have successful models for a physician union<sup>8</sup>; and  
34

35 Whereas, There is no national physician union representing physicians of all specialties in the  
36 U.S.; therefore be it  
37

38 RESOLVED, That our American Medical Association study the feasibility of a national house-  
39 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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<sup>3</sup> Reed Abelson and Julie Creswell, "The Disappearing Doctor: How Mega-Mergers Are Changing the Business of Medical Care," *The New York Times*, April 7, 2018, <https://www.nytimes.com/2018/04/07/health/health-care-mergers-doctors.html>.

<sup>4</sup> Brendan Murphy, "For first time, physician practice owners are not the majority," *AMA Wire*, May 31, 2017, <https://wire.ama-assn.org/practice-management/first-time-physician-practice-owners-are-not-majority>.

<sup>5</sup> Union of American Physicians and Dentists (UAPD), <https://www.uapd.com/all-doctors-need-a-union/>.

<sup>6</sup> Noam Scheiber, "Doctors Unionize to Resist the Medical Machine," *The New York Times*, January 9, 2016, <https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html>.

<sup>7</sup> Margalit Gur-Arie, "Physicians must unionize. Here's why.," *KevinMD.com*, January 12, 2015, <https://www.kevinmd.com/blog/2015/01/physicians-must-unionize-heres.html>.

<sup>8</sup> Yngre Laeger, <https://www.laeger.dk/information-in-english-yngre-laeger>.

## **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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607  
(A-19)

Introduced by: American Society of Clinical Oncology

Subject: Re-Establishment of National Guideline Clearinghouse

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

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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.

Citation: (CMS Rep. D, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

### 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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608  
(A-19)

Introduced by: Resident and Fellow Section

Subject: Financial Protections for Doctors in Training

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

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1 Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and

2  
3 Whereas, With Resident and Fellowship Matching, physicians do not have choice in the benefit  
4 package causing differences in retirement outcomes; and

5  
6 Whereas, Physicians should be saving 15% of their funding towards retirements, but studies  
7 have shown that physicians have not been saving enough due to multiple reason including  
8 significant student debt, delayed start in professional life, and decreased financial literacy<sup>1,2,3</sup>;  
9 and

10  
11 Whereas, Evidence has shown that employers who match retirement savings, result in  
12 employees saving significantly more annual for retirement<sup>4</sup>; therefore be it

13  
14 RESOLVED, That our American Medical Association support retirement plans for all residents  
15 and fellows, which includes retirement plan matching in order to further secure the financial  
16 stability of physicians and increase financial literacy during training (New HOD Policy); and be it  
17 further

18  
19 RESOLVED, That our AMA support that all programs provide financial advising to resident and  
20 fellows. (New HOD Policy)

Fiscal Note: Indeterminate.

Received: 05/01/19

### References:

1. <https://communications.fidelity.com/pdf/physicians-financial-checkup.pdf>
2. [https://www.amainsure.com/research-reports/2017-financial-preparedness-resident-physicians/index.html?page=1&utm\\_source=AMA%20Wire](https://www.amainsure.com/research-reports/2017-financial-preparedness-resident-physicians/index.html?page=1&utm_source=AMA%20Wire)
3. <https://www.mededpublish.org/manuscripts/847/v1>
4. [http://www.plansponsor.com/Employer\\_Contributions\\_Important\\_to\\_Employee\\_Retirement\\_Savings.aspx](http://www.plansponsor.com/Employer_Contributions_Important_to_Employee_Retirement_Savings.aspx)

## 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 recertification 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.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609  
(A-19)

Introduced by: Women Physicians Section

Subject: Update to AMA Policy H-525.998, "Women in Organized Medicine"

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

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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

Whereas, The fifth clause of AMA Policy H-525.998, "Women in Organized Medicine," states 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 implemented<sup>1</sup> and since been superseded by current AMA policy; therefore be it

1 RESOLVED, That our AMA amend AMA Policy H-525.998, "Women in Organized Medicine," by  
2 deletion to read as follows:

3  
4 Our AMA:

5 (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the  
6 medical profession;

7 (2) supports the concept of increased tax benefits for working parents;

8 (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms  
9 its position on child care facilities in or near medical centers and hospitals; (c) encourages  
10 business and industry to establish employee child care centers on or near their premises  
11 when possible; and (d) encourages local medical societies to survey physicians to  
12 determine the interest in clearinghouse activities and in child care services during medical  
13 society meetings; and

14 (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased  
15 availability of such programs; ~~and~~

16 ~~(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and~~  
17 ~~Grievance Procedures be updated by the AMA Women Physicians Congress, and~~  
18 ~~forwarded to the House of Delegates for approval, and include not only resources for~~  
19 ~~training programs but also private practice settings. To facilitate wide distribution and easy~~  
20 ~~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

1. Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures. *JAMA*. 1992;268(2):273.

### 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.

Citation: (BOT Rep. T, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Modified: CME Rep. 3, A-03; Reaffirmed: CCB/CLRPD Rep. 4, A-13)

#### 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610  
(A-19)

Introduced by: Illinois

Subject: Mitigating Gender Bias in Medical Research

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

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1 Whereas, A study published in the *Canadian Medical Association Journal* has shown that grant  
2 applications going through the peer review process submitted by women are scored lower than  
3 those submitted by men; and  
4

5 Whereas, A study has shown that university professors in the basic sciences identified male  
6 applicants as superior to female applicants and deserving of higher compensation even though  
7 the application materials submitted were identical except for the names identifying them as male  
8 or female; and  
9

10 Whereas, A study looking at the relationship between gender and the length and tone of letters  
11 of reference showed that female applicants were only half as likely as male applicants to receive  
12 an “excellent” letter versus a “good” letter, and that letters of reference for women applicants  
13 included substantially different adjectives, such as “diligent” and “hardworking,” as opposed to  
14 “brilliant” and “trailblazer” used to describe male applicants; and  
15

16 Whereas, Our AMA has comprehensive policy on gender equity within the organization and has  
17 committed to presenting a report at the 2019 Annual Meeting; and  
18

19 Whereas, Our AMA has some policy relating to gender equity in regards to physician  
20 compensation and advancement, but nothing specifically relating to gender equity in academic  
21 or commercial medical research; therefore be it  
22

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

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

Received: 04/25/19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611  
(A-19)

Introduced by: Radiological Society of North America, American Society for Radiation  
Oncology, American Institute of Ultrasound in Medicine, Iowa

Subject: Election Reform

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

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1 Whereas, There is an arms race in terms of the number of emails, social media posts,  
2 handwritten notes and mailers which consumes thousands of hours of time when candidates  
3 and their team could be participating in online testimony and preparing for the AMA meeting;  
4 and  
5

6 Whereas, Our candidates attend up to 30 interviews across the Federation consuming at least 5  
7 hours of interview time alone not including traveling time; and  
8

9 Whereas, Most have an “entourage” of 2 to 15 people which means that at least 10-75 hours of  
10 time is taken from their participation in their delegation deliberations and debate; and  
11

12 Whereas, For the elections in 2018 with 24 people running in competitive elections this  
13 amounted to about 1800 hours of lost time at the meeting; and  
14

15 Whereas, This time is a gross underestimation of the time involved given the walking between  
16 sessions; and  
17

18 Whereas, This does not take into account the time taken from each delegation to participate in  
19 the interview process and the time spent waiting for candidates; and  
20

21 Whereas, Candidates and campaign teams remain distracted by their campaigns throughout the  
22 reference committees and even during the business of the House of Delegates; and  
23

24 Whereas, Even after the primary election, runoffs can consume a tremendous amount of time  
25 since they are done with paper; and  
26

27 Whereas, Sponsoring societies spend extensive resources in the form of time and money to  
28 support their individual candidates; and  
29

30 Whereas, Many qualified candidates from the House of Delegates have chosen not to run  
31 campaigns because the burden in terms of money and manpower are prohibitive; and  
32

33 Whereas, The election process has not been updated in several years despite both our House  
34 otherwise going paperless and additional security and technology advancements during that  
35 time; and



Whereas, Many specialty societies already hold web-based or device-based elections with no perceived violation of security or confidence in the outcome; therefore be it

RESOLVED, That our American Medical Association create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making (Directive to Take Action); and be it further

RESOLVED, That our AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:

- a) Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
- b) Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
- c) Separating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices)
- d) An easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail.
- e) Electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in order to facilitate timely results and minimal interruptions to the business.
- f) Seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.
- g) Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.) (Directive to Take Action); and be it further

RESOLVED, That the task force report back to the HOD at the 2019 Interim meeting. (Directive to Take Action)

Fiscal Note: Estimated cost of \$15K-\$25K to implement resolution.

Received: 05/02/19

## RELEVANT AMA POLICY

### Elections. B-3.4

3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

#### 3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each

vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.

3.4.2.3 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.4 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.5 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

### **Rules for AMA Elections G-610.020**

(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. The Speakers may use additional means to make delegates aware of those members intending to seek election;

(3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

(4) An Election Manual containing information on all candidates for election shall continue to be

developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;

(6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;

(13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA

website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Citation: CLRPD Rep. E, I-80; Res. 22, I-81; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CLRPD Rep. F, I-91; CCRC Special Report, I-92; CCRC Special Report I-93; Special Committee on Campaign and Elections and Reaffirmed Special Committee Report on Campaigns and Elections, I-96; Special Committee on Campaigns and Elections, A-97; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01; CC&B Rep. 3, I-08; Modified: Rules and Credentials Rep. 1, A-11; Modified: Rules and Credentials Rep. 1, I-13; Appended: BOT Rep. 5, I-13; Modified: Res. 602, A-14; Modified: Speakers Rep. 1, I-14; Modified: Res. 1, A-15

### **Guiding Principles for House Elections G-610.021**

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

- (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
- (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
- (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
- (4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
- (5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
- (6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

Citation: (CLRPD Rep. 4, I-01; Reaffirmed: CC&B Rep. 2, A-11)

### **Election Process G-610.030**

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

Citation: (Sub. Res. 3, I-74; Special Committee Report, A-86; Reaffirmed: CLRPD Rep. C, A-89; Amended: Sunset Report, I-96; Amended: Rep. of the Special Advisory Committee to the Speaker of the HOD, I-99; Reaffirmed: Sunset Report, A-00; BOT Report 23, A-01; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612  
(A-19)

Introduced by: New Mexico

Subject: Request to AMA for Training in Health Policy and Health Law

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

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1 Whereas, Healthcare in the United States is being largely managed and reshaped by hospital  
2 administrators, consultants and politicians, with relatively little substantive input from physicians;  
3 and  
4

5 Whereas, Physicians who care for patients understand better than anyone the ways in which  
6 our healthcare system is broken and needs to be improved; and  
7

8 Whereas, Dysfunction of our healthcare system and lack of opportunities for physicians to have  
9 a meaningful voice in bringing about needed changes, are significant contributing factors to  
10 physician dissatisfaction, frustration and burnout; and  
11

12 Whereas, Physicians are disadvantaged by the lack of easily available education in health  
13 policy and health law, essential skills for navigating barriers and effecting change; and  
14

15 Whereas, Existing fellowships in health policy and health law offered by outside organizations  
16 tend to promote the values and priorities of those organizations; therefore be it  
17

18 RESOLVED, That our American Medical Association offer its members training in health policy  
19 and health law, and develop a fellowship in health policy and health law. (Directive to Take  
20 Action)

Fiscal Note: Estimated cost of \$200,000 to implement resolution.

Received: 05/09/19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613  
(A-19)

Introduced by: Minority Affairs Section

Subject: Language Proficiency Data of Physicians in the AMA Masterfile

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

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1 Whereas, The U.S. population's linguistic demographics continue to diversify with over 350  
2 languages spoken in the U.S.;<sup>1</sup> and  
3

4 Whereas, Population estimates regarding individuals with limited English proficiency (LEP)  
5 suggest there are over 25 million people with LEP in the U.S., the majority (64%) of whom are  
6 Spanish speakers,<sup>2-3</sup> and with substantial additional population who may not have general LEP  
7 but may have difficulty communicating in English during medical encounters due to the  
8 complexity of health-related cultural-linguistic elements, illness-related stressors, and other  
9 concomitant access-to-care challenges in minority populations;<sup>4-6</sup> and  
10

11 Whereas, The federal government mandates that health care be provided equitably to patients  
12 in their preferred language regardless of national origin or language preference;<sup>7-8</sup> and  
13

14 Whereas, Data demonstrates that language concordance, defined as direct patient-physician  
15 communication in the same language, improves patient outcomes and satisfaction;<sup>9-11</sup> and  
16

17 Whereas, Data demonstrates that language concordant care is superior to professional  
18 interpreter-mediated medical care;<sup>12-13</sup> and  
19

20 Whereas, A majority of medical schools report offering opportunities for linguistic education for  
21 medical students in languages other than English (e.g. medical Spanish) due to patient  
22 population demographic needs and increasing student demand;<sup>17</sup> and  
23

24 Whereas The long-term outcomes of medical school education in non-English medical  
25 communication skills, such as appropriate interpreter use,<sup>18-19</sup> cultural competency, and  
26 linguistic training (e.g., medical Spanish)<sup>20</sup> are currently unknown and would require collection  
27 and evaluation of physician language proficiency data; and  
28

29 Whereas, Existing language concordance preliminary data of primary care providers' languages  
30 conducted in California demonstrates a gross language concordance mismatch compared to the  
31 regional population linguistic profile,<sup>21</sup> and conducting similar studies locally, regionally, and  
32 nationally would enable a needs assessment of available physician resources with regards to  
33 underserved populations; and

Whereas, the Six-point Physician Linguistic Proficiency Self-assessment Scale, from the *Adapted International Language Roundtable (ILR) Scale for Physicians*<sup>23</sup> can measure language fluency as follows:

- **Excellent** – Speaks proficiently, equivalent to that of an educated speaker, and is skilled at incorporating appropriate medical terminology and concepts into communication. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural references.
- **Very Good** – Able to use the language fluently and accurately on all levels related to work needs in a healthcare setting. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech. Language ability only rarely hinders him/her in performing at task requiring language; yet, the individual would seldom be perceived as a native.
- **Good** – Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics. Although cultural references, proverbs and the implications of nuances and idiom may not be fully understood, the individual can easily repair the conversation. May have some difficulty communicating necessary health concepts.
- **Fair** – Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar. The individual can get the gist of most everyday conversations but has difficulty communicating about healthcare concepts.
- **Poor** – Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry level questions. May require slow speech and repetition to understand. Unable to understand or communicate most healthcare concepts.
- **None** – Unable to function in the spoken language. Oral production is limited to occasional isolated words. Has essentially no communicative ability; therefore be it

RESOLVED, That our American Medical Association initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted ILR-scale for physicians to indicate their level of proficiency for each language besides English in the healthcare settings. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

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## RELEVANT AMA POLICY

### **Support of Multilingual Assessment Tools for Medical Professionals H-160.914**

Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages.

Citation: (Res. 703, A-12)

### **Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924**

AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;

(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;

(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and

(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

Citation: BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

### **Interpretive Services H-215.982**

Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services.

Citation: (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: Res. 702, A-12)

### **Medical School Language Electives in Medical School Curriculum H-295.870**

Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives.

Citation: Res. 304, A-07; Reaffirmed: CME Rep. 01, A-17

### **Increasing Access to Healthcare Insurance for Refugee Populations H-350.956**

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

Citation: Res. 006, A-17

### **Interpreter Services and Payment Responsibilities H-385.917**

Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.

Citation: (CMS Rep. 5, A-11)

### **Patient Interpreters H-385.928**

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.

Citation: (Res. 219, I-01; Reaffirmed: BOT Rep 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-14)

### **Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929**

It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive,

ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.

Citation: BOT Rep. 25, I-01; Reaffirmation I-03; Reaffirmed: Res. 907, I-03; Reaffirmation A-09; Reaffirmation: A-17

#### **Interpreters For Physician Visits D-90.999**

Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

Citation: (BOT Rep. 15, I-98; Reaffirmation I-03; Modified: BOT Rep. 28, A-13; Reaffirmation A-14

#### **Appropriate Reimbursement for Language Interpretive Services D-160.992**

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.

2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

Citation: Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14; Reaffirmation: A-17

#### **Certified Translation and Interpreter Services D-385.957**

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Citation: Res. 703, A-17

#### **Language Interpreters D-385.978**

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;

(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;

(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;

(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and

(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

Citation: Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

#### **E-8.5 Disparities in Health Care**

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

[AMA Principles of Medical Ethics: I, IV, VII, VIII, IX](#)

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614  
(A-19)

Introduced by: Minority Affairs Section

Subject: Racial and Ethnic Identity Demographic Collection by the AMA

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

Whereas, An estimated 108 million adults (33% of the adult population) in the United States are Black or African American, American Indian and Alaska Native, Native Hawaiian or Other Pacific Islander, or Hispanic or Latino;<sup>1</sup> and

Whereas, Only 9.2% of practicing physicians are historically underrepresented minority groups in medicine (URMs)<sup>2</sup>; and

Whereas, Physicians who are minorities are more likely to serve those communities and addressing the need for more minority physicians may help mitigate the continued disparities in health outcomes seen within unrepresented minority populations in the US;<sup>3</sup> and

Whereas, Medical organizations (e.g. Association of American Medical Colleges) collect racial and ethnic minority identity demographics<sup>4</sup>; and

Whereas, Pursuant to AMA Policy G-635.125, the AMA gathers stratified demographics of its AMA membership, the nature of which includes age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty; and

Whereas, The AMA does not consistently collect race/ethnicity data from its membership; and

Whereas, The AMA does not have existing policy to consistently collect racial and ethnic minority status in the AMA Physician Masterfile for medical students, residents, fellows, and practicing physicians; and

Whereas, Consistent collection of race/ethnicity data will empower the AMA to address workforce diversity and the professional needs of underrepresented minority medical students, residents, fellows, and practicing physicians; therefore be it

<sup>1</sup> United States Census Bureau Population Estimates, Available for URL: <https://www.census.gov/quickfacts/fact/table/US/PST045218>. Accessed on April 14, 2019

<sup>2</sup> Deville C, Hwang WT, Burgos R, Chapman CH, Both S, Thomas CR Jr. Diversity in Graduate Medical Education in the United States by Race, Ethnicity, and Sex, 2012. *JAMA Intern Med.* 2015 Oct;175(10):1706-8. doi: 10.1001/jamainternmed.2015.4324.

<sup>3</sup> Johnson SR. Black and Hispanic doctors still underrepresented in the U.S <https://www.modernhealthcare.com/article/20150824/NEWS/150829945/black-and-hispanic-doctors-still-underrepresented-in-the-u-s>. Accessed on April 14, 2019

<sup>4</sup> American Association of Medical Colleges (AAMC) Total Enrollment by U.S. Medical School and Race/Ethnicity (Alone), 2018-2019. Available at <https://www.aamc.org/download/321540/data/factstableb5-1.pdf> Accessed on April 14, 2019

- 1 RESOLVED, That our American Medical Association develop a plan with input from the Minority
- 2 Affairs Section and the Chief Health Equity Officer to consistently include racial and ethnic
- 3 minority demographic information for physicians and medical students. (Directive to Take
- 4 Action)

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

Received: 05/09/19

## **RELEVANT AMA POLICY**

### **AMA Membership Demographics G-635.125**

1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and BOT Rep. 26, A-10 Reaffirmed: CCB/CLRPD Rep. 3, A-12 Appended: Res. 603, A-17

### **The Demographics of the House of Delegates G-600.035**

1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.
3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty CCB/CLRPD Rep. 3, A-12 Appended: Res. 616, A-14 Appended: CLRPD Rep. 1, I-15 Modified: Speakers Rep., I-17

### **Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

### **Revisions to AMA Policy on the Physician Workforce H-200.955**

It is AMA policy that:

- (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
- (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will

independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.

(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.

(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.

(5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.

(6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.

(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10;

Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17

#### **Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322**

Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.

Citation: (Res. 313, A-09; Modified: CME Rep. 6, A-11

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615  
(A-19)

Introduced by: Medical Student Section

Subject: Implementing AMA Climate Change Principles Through JAMA Paper  
Consumption Reduction and Green Healthcare Leadership

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

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Whereas, The World Health Organization (WHO) has declared climate change to be the greatest threat to global health in the 21st century, with expected consequences including the spread of disease, drought, and forced migration secondary to the increased incidence of destructive weather events<sup>1</sup>; and

Whereas, The American Medical Association has adopted policy in support of initiatives that promote environmental sustainability and efforts to halt global climate change, including H-135.923 and H-135.938<sup>2</sup>; and

Whereas, Despite the gravity and medical relevance of these phenomena, there is a lack of clarity on the roles of health professionals, organizations, and governments in responding to or implementing policies and action plans in this vital area; and

Whereas, The AMA previously recommended communicating with patients through text, email and telephone to increase access to care, save patients time and fuel cost, and help reduce the overall footprint of obtaining care<sup>3</sup>; and

Whereas, The AMA has also recommended that medical practices and facilities “[p]rint double-sided or go paperless with an electronic health record, and [u]se a digital fax system in which fax images are received through email instead of on paper”<sup>4</sup>; and

Whereas, The *Journal of the American Medical Association (JAMA)* is editorially independent, but an associated and reflective publication of the principles of the AMA<sup>5</sup>; and

Whereas, *JAMA* currently automatically enrolls members of the Medical Student Section in a weekly hard-copy subscription in addition to sending an online copy via email; and

Whereas, Reducing the quantity of printed pages could result in substantial savings for *JAMA*, and the AMA at large, which could directed to pursue other AMA policy priorities and would be consistent with the AMA’s public exhortations to “go green”<sup>6</sup>; and

Whereas, Reduction in paper waste by eliminating redundant hard copy subscriptions would reduce the AMA’s carbon footprint, and comply with the *AMA Journal of Ethics* and American College of Physicians (ACP) recommendations that “physicians should support policies that could help mitigate the health consequences of climate change and advocate for environmentally sustainable practices to be implemented in health facilities”<sup>7</sup>; therefore be it

- 1 RESOLVED, That our American Medical Association change existing automatic paper *JAMA*
- 2 subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to
- 3 receive paper *JAMA*, in order to support broader climate change efforts. (Directive to Take
- 4 Action)

Fiscal Note: not yet determined.

Received: 05/09/19

References:

1. WHO calls for urgent action to protect health from climate change – Sign the call. World Health Organization. <http://www.who.int/globalchange/global-campaign/cop21/en/>. Published April 14, 2016. Accessed September 22, 2018.
2. AMA Adopts New Policies to Improve Health of Nation. Selecting & Using a Health Information Exchange | AMA. <https://www.ama-assn.org/ama-adopts-new-policies-improve-health-nation>. Published November 15, 2016. Accessed September 22, 2018.
3. Lower Costs by Going Green! <https://www.ama-assn.org/sites/default/files/media-browser/public/ps2/transition-green-physician-practice.pdf>. Published 2017. Accessed September 22, 2018.
4. Lower Costs by Going Green! <https://www.ama-assn.org/sites/default/files/media-browser/public/ps2/transition-green-physician-practice.pdf>. Published 2017. Accessed September 22, 2018.
5. Davies HTO, Rennie D. Independence, Governance, and Trust: Redefining the Relationship Between JAMA and the AMA. *JAMA*. 1999;281(24):2344–2346. doi:10-1001/pubs.JAMA-ISSN-0098-7484-281-24-jed90044
6. Lower Costs by Going Green! <https://www.ama-assn.org/sites/default/files/media-browser/public/ps2/transition-green-physician-practice.pdf>. Published 2017. Accessed September 22, 2018.
7. AMA Adopts New Policies to Improve Health of Nation. Selecting & Using a Health Information Exchange | AMA. <https://www.ama-assn.org/ama-adopts-new-policies-improve-health-nation>. Published November 15, 2016. Accessed September 22, 2018.

## RELEVANT AMA POLICY

### AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. Citation: Res. 924, I-16

### Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.



6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: (CSAPH Rep. 3, I-08; Reaffirmation A-14

**AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921**

1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.

2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

Citation: BOT Rep. 34, A-18

**Global Climate Change - The "Greenhouse Effect" H-135.977**

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate

simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;

(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;

(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and

(5) encourages humanitarian measures to limit the burgeoning increase in world population.

Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10;

Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

**Stewardship of the Environment H-135.973**

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616  
(A-19)

Introduced by: Minority Affairs Section  
Subject: TIME'S UP Healthcare  
Referred to: Reference Committee F  
(Greg Tarasidis, MD, Chair)

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1 Whereas, TIME'S UP was established in response to the common experience of power inequity  
2 and unsafe workplaces for women and other underrepresented groups everywhere, women in  
3 healthcare took notice; and  
4

5 Whereas, TIME'S UP launched one year ago, women from across industries have come  
6 together to address systemic inequality and injustice in the workplace; and  
7

8 Whereas, The TIME'S UP Healthcare initiative (<https://www.timesuphealthcare.org>) launched on  
9 February 28, 2019; and  
10

11 Whereas, TIME'S UP Healthcare is a non-profit initiative of the Time's Up Foundation, which  
12 insists on safe, fair and dignified work for women in all healthcare settings; and  
13

14 Whereas, The mission of TIME'S UP Healthcare is to unite national efforts to bring equity,  
15 inclusion and safety to the healthcare industry; and  
16

17 Whereas The TIME'S UP raises awareness and knowledge about inequity and harassment and  
18 their effect on healthcare; and  
19

20 Whereas, TIME'S UP Healthcare is adding its voice to that effort and calling for systemic  
21 change in the workplace culture in healthcare; and  
22

23 Whereas, Although women make up over 80% of the healthcare workforce, the decision  
24 makers, including hospital leadership, executives and association presidents, are largely men;  
25 and  
26

27 Whereas, Physicians continue to work in environments highly tolerant of gender-based  
28 harassment; and  
29

30 Whereas, Gender-based harassment undermines women's professional and educational  
31 attainment and mental and physical health; and  
32

33 Whereas, Gender-based harassment has negative effects of psychological well-being; and  
34

35 Whereas, At the 2018 Annual Meeting of the American Medical Association House of  
36 Delegates, powerful testimony was delivered about the experiences of members and staff who  
37 have experienced harassment at AMA meetings and facilities; and

1 Whereas, The Board of Trustees responded to the will of the House to enact policies that will  
2 decrease the likelihood of gender-based harassment experienced by AMA staff or members;  
3 and  
4

5 Whereas, TIME'S UP "partners" are organizations and societies/associations that have the  
6 ability to work to develop policies and education to transmit to their members; and  
7

8 Whereas, TIME'S UP partners (as of March 8, 2019) include American College of Physicians,  
9 American Nurses Association, American Medical Women's Association, Council of Medical  
10 Specialty Societies, National Medical Association, and Service Employees International Union  
11 (SEIU); and  
12

13 Whereas, TIME'S UP partners pledge their commitment to and alignment with TIME'S UP  
14 Healthcare core statements confirming:  
15

- 16 - that sexual harassment and gender inequity have no place in the healthcare workplace;
- 17 - that we are committed to preventing sexual harassment and gender inequity and  
18 protecting and aiding those who are targets of harassment and discrimination;
- 19 - that we believe every employee should have equitable opportunity, support, and  
20 compensation;
- 21 - that we cannot address a problem without understanding its scope and impact;
- 22 - that we will measure and track sexual harassment and gender-based inequities occurring  
23 in our institution; and  
24

25 Whereas, The process is not associated with a fee and takes less than two minutes to complete  
26 the electronic form on the TIME's UP Healthcare website; and  
27

28 Whereas, By becoming a TIME'S UP partner, our American Medical Association would publicly  
29 demonstrate our commitment to strengthen the structures, processes, and outcomes that will  
30 allow us to achieve safe, dignified, and equitable workplace and environment; therefore be it  
31

32 RESOLVED, That our American Medical Association evaluate TIME'S UP Healthcare program  
33 and consider participation as a TIME'S UP partner in support of our mutual objectives to  
34 eliminate harassment and discrimination in medicine with report back at the 2019 Interim  
35 Meeting. (Directive to Take Action)

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

Received: 05/09/19

## **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.

[ 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617  
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Disabled Physician Advocacy

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

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1 Whereas, Physicians with disabilities can be stigmatized, marginalized in society as a whole  
2 and within the medical community; and  
3

4 Whereas, Physicians with disabilities can provide valuable services not only to patients, but also  
5 to their practices and the community of medicine; and  
6

7 Whereas, Physicians with disabilities have specific legal rights to accommodation and absence  
8 of discrimination of which they may not be aware; and  
9

10 Whereas, Physicians with disabilities may experience profound social, cultural and economic  
11 disadvantage and exclusion; and  
12

13 Whereas, Promoting progressive removal of barriers to the full and effective participation of  
14 persons with disabilities in all aspects of development, and promoting the equal enjoyment by  
15 persons with disabilities of civil, political, economic, social and cultural rights will further the  
16 equalization of opportunities and contribute to the realization of a "society for all" in the twenty-  
17 first century; and  
18

19 Whereas, Disabled physicians would benefit from the identification of support groups, resources  
20 for retraining, opportunities to work with medical students, residents and physicians in practice  
21 as well as all other resources to facilitate their inclusion in the medical community; therefore be  
22 it  
23

24 RESOLVED That our American Medical Association study and report back on eliminating  
25 stigmatization and enhancing inclusion of disabled physicians including but not limited to:  
26

27 1) Enhancing representation of disabled physicians within the AMA.  
28

29 2) Examining support groups, education, legal resources and any other means to  
30 increase the inclusion of physicians with disabilities in the AMA (Directive to Take  
31 Action); and be it further  
32

33 RESOLVED That our AMA identify medical, professional and social rehabilitation, education,  
34 vocational training and rehabilitation, aid, counseling, placement services and other services  
35 which will enable disabled physicians to develop their capabilities and skills to the maximum and  
36 will hasten the processes of their social and professional integration or reintegration. (Directive  
37 to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

1. General website identifying issues and needs of physicians with disabilities <https://www.physicianswithdisabilities.org/>
2. <https://journalofethics.ama-assn.org/article/why-increasing-numbers-physicians-disability-could-improve-care-patients-disability/2016-10>
3. <https://www.nytimes.com/2017/07/11/upshot/doctors-with-disabilities-why-theyre-important.html>
4. AAMC report: Accessibility, Inclusion, and Action in Medical Education Lived Experiences of Learners and Physicians With Disabilities March 2018
5. The Physically Disabled Physician <https://jamanetwork.com/journals/jama/article-abstract/366379>
6. DeLisa JA, Thomas P: Physicians with disabilities and the physician workforce: A need to reassess our policies. Am J Phys Med Rehabil 2005;84:5–11.
7. Zazove P, Case B, Moreland C, et al. U.S. medical schools' compliance with the Americans with Disabilities Act: findings from a national study. Acad Med. 2016;91(7):979-986.
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11. Meeks LM, Herzer KR. Accommodated MCAT time and performance measurements. JAMA. 2015;314(14):1517-1518.[ArticlePubMedGoogle ScholarCrossref](#)
12. Searcy CA, Dowd KW, Hughes MG, Baldwin S, Pigg T. Association of MCAT scores obtained with standard vs extra administration time with medical school admission, medical student performance, and time to graduation. JAMA. 2015;313(22):2253-2262.[ArticlePubMedGoogle ScholarCrossref](#)
13. University of California San Francisco. The Coalition for Disability Access in Health Science and Medical Education. 2015. <http://meded.ucsf.edu/msds/coalition>. Accessed February 13, 2016.
14. Health Care Professionals with Disabilities Career Trends, BestPractices and Call-to-Action Policy Roundtable <https://www.dol.gov/odep/alliances/nondallianceroindentablereport.pdf>