AMA
AMERICAN MEDICAL ASSOCIATION

MEMBERSHIP MOVES MEDICINE™

2020

Special Meeting of the AMA House of Delegates

Visit ama-assn.org/sm20-hod-business to access the handbook online.

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.

Official Call to Special Meeting of the House of Delegates

To: Delegates and Alternate Delegates
From: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Pursuant to the unanimous action of the American Medical Association (AMA) Board of Trustees (BOT) on April 25, 2020, this notice will serve as the official call to convene a Special Meeting of the AMA House of Delegates (HOD) on June 7, 2020 at 2:00 pm CT. This Special Meeting will be convened on a virtual platform.

The purpose of this meeting as defined by the request of the BOT is to inaugurate our new president, to elect officers and members of councils, and to conduct essential business that would otherwise be required to be addressed at an annual meeting of the HOD.

ESSENTIAL BUSINESS AND PROCESS:

- Business to be considered will be limited to the essential items as above. At the current time it appears this will be about 10 items. Per our bylaws (2.12.2) for Special Meetings of the HOD, no other business will be considered.
- No other resolutions or reports beyond these required items will be considered. Extensive consideration has been given in reaching the decision to limit the items of business. While the desire of many members to discuss certain items that may be felt to be urgent or pertinent to our current national situation is understood, our rules have no mechanism which allows us to screen or limit items of business other than the motion to object to consideration, which itself is subject to debate for each item of business. For this reason and in keeping with Bylaws 2.12.2, the business of the Special Meeting has been narrowly defined as described.
- Given this meeting's narrow focus, your speakers will work with the Resolution Committee at our November HOD meeting to accept items of business beyond those related to advocacy and legislation.
- Reference Committee F will be convened online to allow testimony on the limited business of this Special Meeting. The online reference committee will remain open for several days to allow delegates ample opportunity to comment. The HOD will be notified when the reference committee is open for testimony.
- As in "live" reference committee testimony, those testifying will be asked to identify their role (Delegate/Alternate from State/Specialty or member representing sections etc.) and whether they are commenting on behalf of a delegation or on behalf of themselves as individuals. Conflicts of interest, if any, should also be declared with each comment. Online testimony may include amendment suggestions, with specific wording clearly delineated.
- Following the close of the virtual reference committee "hearing," the members of Reference Committee F will prepare a reference committee report which will be presented to the HOD as a consent calendar.
- This consent calendar will then be the business of the HOD at the Special Meeting.
- A handbook with business to be considered and useful information will be sent as soon as assembled. This will include the roster of delegates and alternate delegates.
- If the credential information for your delegation has changed please contact Patti.Wargo@ama-assn.org.
- Delegates and Alternate Delegates please confirm your contact information, specifically confirm an email address (if this email arrived at your preferred address, you may consider this accomplished), as much of our meeting will be dependent on the ability to reach delegates electronically. In addition credentialing information for secure voting will be sent by email.
- A notice will be sent shortly announcing the Board's nominations for Councils. Active campaigning for officer and council candidates will be allowed at this point.

Being respectful of the challenges we all face during this pandemic, the limitation to essential business only, combined with some additional efficiencies your speakers plan, will expedite our meeting allowing us to hopefully complete our Special Meeting within 2 hours. Your speakers want to assure you that we are planning a virtual meeting with secure voting and protection of participants' rights. Having just received the request to "call" the Special Meeting we wanted to get this notice out to you as soon as possible. Further details will be forthcoming. We request and very much appreciate your patience and cooperation as we journey into new territory for us and our AMA. We look forward to virtually connecting with you on June 7th.

Responses should be directed to HOD@ama-assn.org

April 25, 2020

SPECIAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official call to the Officers and Members of the American Medical Association to participate in a Special Meeting of the House of Delegates on June 7, 2020 at 2:00 p.m. (CT). The 2020 Special Meeting of the House of Delegates will be convened on a virtual platform.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4
Alaska 1
Arizona 5
Arkansas 3
California 33
Colorado 5
Connecticut 4
Delaware 1
District of Columbia 3
Florida 16
Georgia 6
Guam 1
Hawaii 2
Idaho 1
Illinois 12
Indiana 5
Iowa 4
Kansas 3
Kentucky 5
Louisiana 6
Maine 2
Maryland 5
Massachusetts 13
Michigan 13
Minnesota 5
Mississippi 3
Missouri 6
Montana 1
Nebraska 2
Nevada 2
New Hampshire 1
New Jersey 8
New Mexico 2
New York 22
North Carolina 6
North Dakota 1
Ohio 13
Oklahoma 4
Oregon 3
Pennsylvania 14
Puerto Rico 2
Rhode Island 2
South Carolina 5
South Dakota 2
Tennessee 5
Texas 20
Utah 2
Vermont 1
Virgin Islands 1
Virginia 8
Washington 5
West Virginia 2
Wisconsin 5
Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 4
American Academy of Family Physicians 16
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 2
American Academy of Sleep Medicine 2
American Association for Geriatric Psychiatry 2
American Association of Clinical Endocrinologists 2
American Association of Gynecologic Laparoscopists 3
American Association of Neurological Surgeons 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2
American College of Allergy, Asthma and Immunology 2
American College of Cardiology 7
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 8
American College of Gastroenterology 2
American College of Obstetricians and Gynecologists 13
American College of Occupational and Environmental Medicine 2
American College of Physicians 24
American College of Preventive Medicine 2
American College of Radiology 7
American College of Rheumatology 2
American College of Surgeons 13
American Gastroenterological Association 3
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 9
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 2
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society for Reproductive Medicine 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 7
American Society of Breast Surgeons 2
American Society of Cataract and Refractive Surgery 2
American Society of Clinical Oncology 3
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Interventional Pain Physicians 2
American Society of Nuclear Cardiology 2
American Society of Plastic Surgeons 2
American Society of Retina Specialists 2
American Thoracic Society 3
American Urological Association 2
Association of Military Surgeons of the United States 2
College of American Pathologists 4
Congress of Neurological Surgeons 2
Heart Rhythm Society 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Renal Physicians Association 2
Society for Vascular Surgery 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 3
Society of Hospital Medicine 3
Society of Interventional Radiology 2
Society of Laparoendoscopic Surgeons 2
Society of Thoracic Surgeons 2
The Endocrine Society 2
United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (56) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	307
National Medical Specialty Societies	305
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	28
Resident and Fellow Delegate Representatives	28
Sections	10
Services	5
Total Delegates	**689**

Patrice A. Harris, MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Bobby Mukkamala, MD
Secretary

2019-2020

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Patrice A. Harris ..... Atlanta, Georgia
President-Elect - Susan R. Bailey ..... Fort Worth, Texas
Immediate Past President - Barbara L. McAneny ..... Albuquerque, New Mexico
Secretary - Bobby Mukkamala ..... Flint, Michigan
Speaker, House of Delegates - Bruce A. Scott ..... Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert ..... Kettering, Ohio

Grayson W. Armstrong (2021) ..... Boston, Massachusetts
Willarda V. Edwards (2020) ..... Baltimore, Maryland
Jesse M. Ehrenfeld (2022), *Chair* ..... Nashville, Tennessee
Scott Ferguson (2022) ..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2022) ..... Atlanta, Georgia
Gerald E. Harmon (2021) ..... Pawleys Island, South Carolina
William E. Kobler (2020) ..... Rockford, Illinois
Russell W.H. Kridel (2022), *Chair-Elect* ..... Houston, Texas
William A. McDade (2020) ..... Chicago, Illinois
Mario E. Motta (2022) ..... Salem, Massachusetts
Jack S. Resneck, Jr. (2022) ..... San Rafael, California
Sarah Mae Smith (2020) ..... Anaheim, California
Michael Suk (2023) ..... Danville, Pennsylvania
Willie Underwood, III (2023) ..... Buffalo, New York
Kevin W. Williams (2020) ..... Nashville, Tennessee

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Patricia L. Austin, Alamo, California, Chair (2022); Madelyn E. Butler, Tampa, Florida, Vice Chair (2022); Ariel M. Anderson, New York, New York (Resident) (2021); Mark N. Bair, Highland, Utah (2023); Jerome C. Cohen, Loch Sheldrake, New York (2021); Pino D. Colone, West Bloomfield, Michigan (2020); Pauline P. Huynh, Baltimore, Maryland (Student) (2020); Kevin C. Reilly, Sr., Elizabethtown, Kentucky (2022).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Kathryn L. Moseley, Canton, Michigan, Chair (2020); Monique A. Spillman, Dallas, Texas, Vice Chair (2021); Rebecca W. Brendel, Boston, Massachusetts (2026); Kimberly A. Chernoby, Indianapolis, Indiana (Resident) (2021); David Fleming, Columbia, Missouri (2024); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Michael J. Rigby, Madison, Wisconsin (Student) ((2021); Alexander M. Rosenau, Allentown, Pennsylvania (2022); Peter A. Schwartz, Reading, Pennsylvania (2023).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
David T. Tayloe, Jr., Goldsboro, North Carolina, Chair (2020); Marilyn J. Heine, Dresher, Pennsylvania, Vice Chair (2020); David H. Aizuss, Encino, California (2020); Vijaya L. Appareddy, Chattanooga, Tennessee (2020); Hans C. Arora, Cleveland Heights, Ohio (Resident) (2020); Maryanne C. Bombaugh, Falmouth, Massachusetts (2020); Mary S. Carpenter, Winner, South Dakota (2020); Gary W. Floyd, Keller, Texas (2020); Linda B. Ford, Bellevue, Nebraska (AMPAC Observer) (2020); Beth Irish, Bend, Oregon (Alliance Liaison) (2020); Tripti C. Kataria, Chicago, Illinois (2020); Ajeet Singh, Boston, Massachusetts (Student) (2020); Heather Ann Smith, Newport, Rhode Island (2020); Marta J. Van Beek, Iowa City, Iowa (2020).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
James A. Goodyear, Lansdale, Pennsylvania, Chair (2021); Shannon P. Pryor, Washington, DC, Vice Chair (2020); Michelle Berger, Austin, Texas (2022); Edmond B. Cabbabe, St. Louis, Missouri (2021); Clarence P. Chou, Milwaukee, Wisconsin (2020); Rebecca A. Haines, Temple Texas (Student) (2020); Jan M. Kief, Highlands Ranch, Colorado (2023); G. Sealy Massingill, Fort Worth, Texas (2023); Benjamin D. Meyer, Milwaukee, Wisconsin (Resident) (2022); Gary D. Thal, Chicago, Illinois (2021).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Jacqueline A. Bello, New York, New York, Chair (2021); Liana Puscas, Durham, North Carolina, Chair-Elect (2021); Kelly J. Caverzagie, Omaha, Nebraska (2023); Sharon P. Douglas, Madison, Mississippi (2023); Robert B. Goldberg, New York, New York (2021); Cynthia A. Jumper, Lubbock, Texas (2020); Shannon M. Kilgore, Palo Alto, California (2023); Rafa Rahman, Centreville, Virginia (Student) (2020); Niranjan V. Rao, New Brunswick, New Jersey (2022); Luke V. Selby, Denver, Colorado (Resident) (2020); Krystal L. Tomei, Lyndhurst, Ohio (2021); John P. Williams, Gibsonia, Pennsylvania (2023).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
W. Alan Harmon, Jacksonville, Florida, Chair (2020); Lynda M. Young, Worcester, Massachusetts, Chair-Elect (2021); Nonie S. Arora, Novi, Michigan (Student) (2020); A. Patrice Burgess, Boise, Idaho (2023); Betty S. Chu, West Bloomfield, Michigan (2022); Alice Coombs, Richmond, Virginia (2023); Meena Davuluri, New York, New York (Resident) (2020); Stephen K. Epstein, Needham, Massachusetts (2022); Lynn L. C. Jeffers, Oxnard, California (2020); Asa C. Lockhart, Tyler, Texas (2022); Thomas J. Madejski, Albion, New York (2023); Sheila Rege, Kennewick, Washington (2022).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Michael M. Miller, Oconomowoc, Wisconsin, Chair (2022); Kira A. Geraci-Ciardullo, Harrison, New York, Chair-Elect (2022); Ali Bokhari, Brooklyn, New York (Student) (2020); John T. Carlo, Dallas, Texas (2021); Noel N. Deep, Antigo, Wisconsin (2023); Alexander Ding, Belmont, California (2020); Laura E. Halpin, Playa Del Rey, California (Resident) (2022); Mary E. LaPlante, Broadview Heights, Ohio (2021); Tamaan K. Osbourne-Roberts, Denver, Colorado (2023); Padmini D. Ranasinghe, Baltimore, Maryland (2022); Corliss A. Varnum, Oswego, New York (2023); David J. Welsh, Batesville, Indiana (2020).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Lyle S. Thorstenson, Nacogdoches, Texas, Chair; Stephen A. Imbeau, Florence, South Carolina, Secretary; Miriam J. R. Bareman, Grand Rapids, Michigan (Student); Brooke M. Buckley, Annapolis, Maryland; Paul J. Carniol, Summit, New Jersey; Ricardo Correa Marquez, Phoenix, Arizona; Linda B. Ford, Bellevue, Nebraska; Benjamin Z. Galper, McLean, Virginia; Dev A. GnanaDev, Colton, California; Pratistha Koirala, New York, New York (Resident); James L. Milam, Libertyville, Illinois; L. Elizabeth Peterson, Spokane, Washington.
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

David O. Barbe	2017-2018	Ardis D. Hoven	2013-2014	William G. Plested, III	2006-2007
Lonnie R. Bristow	1995-1996	Daniel H. Johnson, Jr.	1996-1997	Thomas R. Reardon	1999-2000
Peter W. Carmel	2011-2012	Jeremy A. Lazarus	2012-2013	J. James Rohack	2009-2010
Yank D. Coble, Jr.	2002-2003	Robert E. McAfee	1994-1995	Randolph D. Smoak, Jr.	2000-2001
Richard F. Corlin	2001-2002	Alan R. Nelson	1989-1990	Steven J. Stack	2015-2016
Nancy W. Dickey	1998-1999	John C. Nelson	2004-2005	Robert M. Wah	2014-2015
Andrew W. Gurman	2016-2017	Nancy H. Nielsen	2008-2009	Cecil B. Wilson	2010-2011
J. Edward Hill	2005-2006	Donald J. Palmisano	2003-2004	Percy Wootton	1997-1998

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Audrey J. Ludwig	1990-1991
Susan Hershberg Adelman	1998-2002	Justin B. Mahida	2009-2010
Kendall S. Allred	2008-2009	Omar Z. Maniya	2016-2017
Raj S. Ambay	2009-2011	Robert E. McAfee	1984-1993
Joseph P. Annis	2006-2014	Mary Anne McCaffree	2008-2016
John H. Armstrong	2002-2006	Joe T. McDonald	2005-2006
Maya A. Babu	2013-2017	Samuel J. Mackenzie	2014-2015
Timothy E. Baldwin	1987-1989	Robert R. McMillan	2002-2008
David O. Barbe	2009-2016	Sandeep “Sunny” Mistry	2000-2001
Regina M. Benjamin	1995-1998	Alan R. Nelson	1980-1988
Scott L. Bernstein	1991-1992	John C. Nelson	1994-2003
Stefano M. Bertozzi	1986-1988	Nancy H. Nielsen	2005-2007
David J. Brailer	1985-1986	Albert J. Osbahr, III	2011-2019
Lonnie R. Bristow	1985-1994	Donald J. Palmisano	1996-2002
Duane M. Cady	1999-2007	Rebecca J. Patchin	1988-1989
Peter Carmel	2002-2010	Rebecca J. Patchin	2003-2011
Alice A. Chenault	1984-1985	Stephen R. Permut	2010-2018
Yank D. Coble	1994-2001	Pamela Petersen-Crair	1996-1998
David S. Cockrum	1993-1994	Dina Marie Pitta	2015-2016
MaryAnn Contogiannis	1989-1993	William G. Plested, III	1998-2005
Malini Daniel	2012-2013	Stephen Pool	1995-1996
Christopher M. DeRienzo	2006-2008	Liana Puscas	1999-2001
Nancy W. Dickey	1989-1997	Thomas R. Reardon	1990-1998
Alexander Ding	2011-2013	Kevin C. Reilly	2003-2005
William A. Dolan	2007-2011	Ryan J. Ribeira	2013-2014
Timothy T. Flaherty	1994-2003	J. James Rohack	2001-2008
Melissa J. Garretson	1992-1993	David A. Rosman	2002-2004
Michael S. Goldrich	1993-1997	Samantha L. Rosman	2005-2009
Julie K. Goonewardene	2012-2016	Raymond Scalettar	1985-1994
Andrew W. Gurman	2007-2015	Bruce A. Scott	1998-2002
Alan C. Hartford	1989-1990	Carl A. Sirio	2010-2018
William A. Hazel, Jr.	2004-2009	Randolph D. Smoak, Jr.	1992-1999
Cyril M. Hetsko	2003-2011	Steven J. Stack	2006-2014
Joseph M. Heyman	2002-2010	Michael Suk	1994-1995
J. Edward Hill	1996-2004	Andrew M. Thomas	1997-1999
Ardis D. Hoven	2005-2012	Jeffrey A. Towson	1998-1999
William E. Jacott	1989-1998	Georgia A. Tuttle	2011-2019
Hillary D. Johnson	2001-2002	Jordan M. VanLare	2011-2012
Matthew D. Kagan	1999-2000	Robert M. Wah	2005-2013
Christopher K. Kay	2008-2012	Peter Y. Watson	2001-2003
Edward L. Langston	2003-2011	Monica C. Wehby	2011-2013
Matthew C. Lawyer	2004-2005	Meredith C. Williams	2010-2011
Jeremy A. Lazarus	2005-2011	Cecil B. Wilson	2002-2009
W. J. Lewis	1979-1984	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates but are representatives of the following societies which are represented in the SSS.)

American Academy of Emergency Medicine	Joseph Wood, MD, JD
American Association of Endocrine Surgeons	Steven De Jong, MD
American Association of Hip and Knee Surgeons	Edward Tanner, MD
American College of Correctional Physicians	Charles Lee, MD
American Contact Dermatitis Society	Bruce Brod, MD
American Epilepsy Society	David M. Labiner, MD
American Society for Laser Medicine and Surgery	George Hruza, MD
American Society of Nuclear Cardiology	Saurabh Malhotra, MD
American Society of Regional Anesthesia and Pain Medicine	Edward Mariano, MD
Americas Hernia Society	John Fischer, MD
Association of Academic Physiatrists	Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology	Christopher R. Shea, MD
Korean American Medical Association	John Yun, MD
Outpatient Endovascular and Interventional Society	Eric Dippel, MD
Society of Cardiovascular Computed Tomography	Dustin Thomas, MD
Society of Gynecologic Oncologists	Carol Brown, MD
American Academy of Addiction Psychiatry	Alena Balasanova, MD
Society for Cardiovascular Magnetic Resonance	Edward Martin, MD

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - JUNE 2020
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate allocation for 2020: 4

Delegate(s)
Jorge Alsip, Daphne AL
Steven P. Furr, Jackson AL
B Jerry Harrison, Haleyville AL
George C. Smith, Jr, Lineville AL

Alternate Delegate(s)
Raymond Broughton, Theodore AL
Harry Kuberg, Russelville AL
John Meigs, Jr, Brent AL
William Schneider, Huntsville AL

Resident and Fellow Sectional Alternate Delegate(s)
Amber Clark, Trussville AL
David Harris, Birmingham AL

Alaska State Medical Association

Delegate allocation for 2020: 1

Delegate(s)
Alex Malter, Juneau AK

Alternate Delegate(s)
Mary Ann Foland, Anchorage AK

Arizona Medical Association

Delegate allocation for 2020: 5

Delegate(s)
Daniel P. Aspery, Phoenix AZ
Veronica K. Dowling, Lakeside AZ
Gary R. Figge, Tucson AZ
Thomas H. Hicks, Tucson AZ
M Zuhdi Jasser, Phoenix AZ

Alternate Delegate(s)
Timothy Fagan, Tucson AZ
Ross F. Goldberg, Scottsdale AZ
Michael Hamant, Tucson AZ
Marc Leib, Phoenix AZ
Elise Molnar, Phoenix AZ

Regional Medical Student Delegate(s)
Akshara Malla, Phoenix AZ

Arizona Medical Association

Delegate allocation for 2020: 5

Regional Medical Student Alternate Delegate(s)
Meera Kapadia, Chandler AZ

Arkansas Medical Society

Delegate allocation for 2020: 3

Delegate(s)
Omar Atiq, Little Rock AR
Eugene Shelby, Little Rock AR
Alan Wilson, Monticello AR

Alternate Delegate(s)
Amy Cahill, White Hall AR
Stephen Magie, Conway AR

Regional Medical Student Delegate(s)
Anveshi Guha, Little Rock AR

California Medical Association

Delegate allocation for 2020: 33

Delegate(s)
Jerry P. Abraham, Los Angeles CA
David H. Aizuss, Encino CA
Barbara J. Arnold, Sacramento CA
Patricia L. Austin, Alamo CA
Edward Bentley, Santa Barbara CA
Peter N. Bretan, Jr, Novato CA
Jacob Burns, Sacramento CA
J Brennan Cassidy, Newport Beach CA
Luther Cobb, Eureka CA
Alexander Ding, Belmont CA
Maisha Draves, Vallejo CA
Kyle P. Edmonds, San Diego CA
Dev A. GnanaDev, Redlands CA
James T. Hay, Del Mar CA
Robert Hertzka, Rancho Santa Fe CA
James G. Hinsdale, San Jose CA
Samuel Huang, Los Angeles CA
Vito Imbasciani, Los Angeles CA
Melissa Jones, Sacramento CA
Kermit Jones, Vacaville CA
Edward Lee, Sacramento CA

California Medical Association

Delegate allocation for 2020: 33

Delegate(s)

Arthur N. Lurvey, Los Angeles CA
Michael Luszczak, Carmichael CA
Ramin Manshadi, Stockton CA
Robert J. Margolin, Tiburon CA
Theodore Mazer, San Diego CA
Kelly McCue, Davis CA
Stephen Parodi, Vallejo CA
Albert Ray, San Diego CA
Neil Rens, Menlo Park CA
Tatiana W. Spirtos, Redwood City CA
Daniel Udrea, Loma Linda CA
Paul Yost, Seal Beach CA

Alternate Delegate(s)

Alan Anzai, Sacramento CA
Dirk Stephen Baumann, Burlingame CA
David Bazzo, San Diego CA
Jeffrey Brackett, Ventura CA
Lawrence Cheung, San Francisco CA
Jack Chou, Baldwin Park CA
James Cotter, Napa CA
Melanie Crane, Riverside CA
Kevin Durgun, Sacramento CA
Suparna Dutta, CA
George Fouras, Los Angeles CA
David Friscia, San Diego CA
Anjalee Galion, Santa Ana CA
Dayna Isaacs, El Dorado Hills CA
Scott Richard Karlan, West Hollywood CA
Nikan Khatibi, Laguna Niguel CA
Jeff Klingman, Orinda CA
Mark H. Kogan, San Pablo CA
Man Kit Leung, San Francisco CA
Ashley McClure, Oakland CA
Sandra Mendez, Sacramento CA
Chang Na, Bakersfield CA
Richard Pan, Sacramento CA
Mihir Parikh, La Jolla CA
Damodara Rajasekhar, Apple Valley CA
Ryan J. Ribeira, Mountain View CA
Sion Roy, Torrance CA
Lorin Scher, Sacramento CA
Seema Sidhu, Fremont CA

California Medical Association

Delegate allocation for 2020: 33

Alternate Delegate(s)

James J. Strebig, Irvine CA
Steven Wang, Sacramento CA
Holly Yang, San Diego CA

Resident and Fellow Sectional Delegate(s)

Hunter Pattison, Sacramento CA

Resident and Fellow Sectional Alternate Delegate(s)

Sophia Yang, San Jose CA

Regional Medical Student Delegate(s)

Drayton Harvey, Los Angeles CA

Regional Medical Student Alternate Delegate(s)

Vinita Shivakumar, Stanford CA
Jonathan You, Stanford CA

Colorado Medical Society

Delegate allocation for 2020: 5

Delegate(s)

David Downs, Denver CO
Jan Kief, Highlands Ranch CO
A. "Lee" Morgan, Denver CO
Tamaan Osbourne-Roberts, Denver CO
Lynn Parry, Littleton CO

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO
Rachelle M. Klammer, Denver CO
Katie Lozano, Centennial CO
Brigitta J. Robinson, Centennial CO
Michael Volz, Englewood CO

Connecticut State Medical Society

Delegate allocation for 2020: 4

Delegate(s)

Michael L. Carius, Stratford CT
Katherine L. Harvey, CT
Alfred Herzog, Hartford CT
Theodore Zanker, Cheshire CT

Alternate Delegate(s)

Kathleen A. LaVorgna, Norwalk CT
Bollepalli Subbarao, Middletown CT
Stacy Taylor, New Hartford CT
Steven C. Thornquist, Bethany CT

Connecticut State Medical Society

Delegate allocation for 2020: 4

Resident and Fellow Sectional Delegate(s)

Pratistha Koirala, CT

Regional Medical Student Delegate(s)

Devin Bageac, CT
Faith Crittenden, Windsor CT

Regional Medical Student Alternate Delegate(s)

Ryan Englander, Farmington CT
Ian Whittall, Farmington CT

Medical Society of Delaware

Delegate allocation for 2020: 1

Delegate(s)

Janice Tildon-Burton, Wilmington DE

Alternate Delegate(s)

Stephanie Howe Guarino, Wilmington DE

Medical Society of the District of Columbia

Delegate allocation for 2020: 3

Delegate(s)

Peter E. Lavine, Washington DC
J Desiree Pineda, Potomac MD
Raymond K. Tu, Washington DC

Alternate Delegate(s)

Neal D Barnard, Washington DC

Regional Medical Student Alternate Delegate(s)

Alicia Khan, DC

Florida Medical Association

Delegate allocation for 2020: 16

Delegate(s)

Christie P. Alexander, Tallahassee FL
Ankush Bansal, Palm Beach Gardens FL
David Becker, Safety Harbor FL
Madelyn E. Butler, Tampa FL
Andrew Cooke, Orlando FL
Mark Dobbertien, Orange Park FL
Ronald Frederic Giffler, Davie FL
Walter Alan. Harmon, Jacksonville FL
Corey L. Howard, Naples FL
Tra'Chella Johnson Foy, Jacksonville FL
John Montgomery, Fleming Island FL

Florida Medical Association

Delegate allocation for 2020: 16

Delegate(s)

Douglas Murphy, Ocala FL
Ralph Jacinto Nobo, Jr, Bartow FL
Michael L. Patete, Venice FL
James St George, Jacksonville FL
Michael Zimmer, St Petersburg FL

Alternate Delegate(s)

Shawn Baca, Boca Raton FL
James Booker, Winter Haven FL
Lisa Cosgrove, Cape Canaveral FL
Aaron Elkin, Hollywood FL
Raphael C. Haciski, Naples FL
Ryan Hall, Lake Mary FL
Lawrence S. Halperin MD, Altamonte Spg FL
Karen Harris, Gainesville FL
Rebecca Lynn Johnson, Tampa FL
Arthur E. Palamara, Hollywood FL
Alan B. Pillersdorf, Lake Worth FL
Sergio B. Seoane, Lakeland FL

Regional Medical Student Delegate(s)

Ian Motie, Tallahassee FL
David Tyson, Gainesville FL

Regional Medical Student Alternate Delegate(s)

Jimmy Cooper, Gainesville FL
Samantha Pavlock, Jupiter FL

Medical Association of Georgia

Delegate allocation for 2020: 6

Delegate(s)

John S. Antalis, Dalton GA
S William Clark, III, Waycross GA
Michael E. Greene, Savannah GA
Billie Luke Jackson, Macon GA
Sandra B. Reed, Atlanta GA

Alternate Delegate(s)

Jack Chapman, Gainesville GA
John Goldman, Atlanta GA
Ali Rahimi, Marietta GA
Gary Richter, Atlanta GA
Charles Wilmer, Atlanta GA

Resident and Fellow Sectional Delegate(s)

Jessica Walsh O'Sullivan, Atlanta GA

Guam Medical Society

Delegate allocation for 2020: 1

Delegate(s)
Edward Blounts, Barrigada GU

Hawaii Medical Association

Delegate allocation for 2020: 2

Delegate(s)
Jone Geimer-Flanders, Honolulu HI
Roger Kimura, Honolulu HI

Alternate Delegate(s)
Christopher Flanders, Honolulu HI

Idaho Medical Association

Delegate allocation for 2020: 1

Delegate(s)
A. Patrice Burgess, Boise ID

Alternate Delegate(s)
Keith Davis, Shoshone ID

Illinois State Medical Society

Delegate allocation for 2020: 12

Delegate(s)
Thomas M. Anderson, Jr, Chicago IL
Christine Bishof, Elmhurst IL
Howard Chodash, Springfield IL
Scott A. Cooper, Chicago IL
Peter E. Eupierre, Oak Brook IL
Steve Malkin, Peoria AZ
James L. Milam, Libertyville IL
Robert Panton, Elmwood Park IL
Nestor Ramirez-Lopez, Champaign IL
Laura Shea, Springfield IL
Shastri Swaminathan, Westmont IL
Piyush Vyas, Lake Forest IL

Alternate Delegate(s)
Rodney Alford, Watseka IL
Smitha Arekapudi, IL
Howard Axe, Grayslake IL
Kenneth G. Busch, Chicago IL
Richard A. Geline, Glenview IL
Tariq Issa, Springfield IL
Niva Lubin-Johnson, Chicago IL
Vikram B. Patel, South Barrington IL
Holly Rosencranz, Champaign IL

Illinois State Medical Society

Delegate allocation for 2020: 12

Alternate Delegate(s)
Katherine Tynus, Chicago IL
Steven D. Williams, Bourbonnais IL

Resident and Fellow Sectional Delegate(s)
Christiana Shoushtari, Chicago IL

Resident and Fellow Sectional Alternate Delegate(s)
Zoran Pavlovic, Chicago IL

Regional Medical Student Delegate(s)
Titus Hou, Loves Park IL

Regional Medical Student Alternate Delegate(s)
Raj Kumar, Rockford IL

Indiana State Medical Association

Delegate allocation for 2020: 5

Delegate(s)
Michael Hoover, Evansville IN
Vidya S. Kora, Michigan City IN
William Mohr, Kokomo IN
Stephen Tharp, Indianapolis IN
David Welsh, Batesville IN

Alternate Delegate(s)
Deepak Azad, Floyds Knobs IN
Heidi Dunniway, Evansville IN
Brent Mohr, Granger IN
Rhonda Sharp, Lagrange IN
Thomas Vidic, Elkhart IN

Regional Medical Student Delegate(s)
Brandon Francis, Evansville IN

Regional Medical Student Alternate Delegate(s)
Megan Chiu, Bloomington IN

Iowa Medical Society

Delegate allocation for 2020: 4

Delegate(s)
Michael Kitchell, Ames IA
Robert Lee, Johnston IA
Victoria Sharp, Iowa City IA

Alternate Delegate(s)
Jeffrey Anderson, IA
Douglas Peters, W Burlington IA

Iowa Medical Society

Delegate allocation for 2020: 4

Alternate Delegate(s)

Brian Privett, Cedar Rapids IA

Kansas Medical Society

Delegate allocation for 2020: 3

Delegate(s)

Robert Gibbs, Parsons KS
Arthur D. Snow, Jr, Shawnee Mission KS
Richard B. Warner, Shawnee Mission KS

Alternate Delegate(s)

Amanda Gudgell, Lawrence KS
LaDona Schmidt, Lawrence KS

Kentucky Medical Association

Delegate allocation for 2020: 5

Delegate(s)

David J. Bensema, Lexington KY
J Gregory Cooper, Cynthiana KY
Bruce A. Scott, Louisville KY
Donald J. Swikert, Edgewood KY

Alternate Delegate(s)

Shawn C. Jones, Paducah KY
Mamata G. Majmundar, KY
Suzanne McGee, Louisville KY
William B. Monnig, Ryland Heights KY
John L. Roberts, Louisville KY

Resident and Fellow Sectional Alternate Delegate(s)

Ariel Carpenter, Louisville KY

Regional Medical Student Alternate Delegate(s)

Alex Thebert, Prospect KY

Louisiana State Medical Society

Delegate allocation for 2020: 6

Delegate(s)

Luis M. Alvarado, Mandeville LA
Susan M. Bankston, LA
Floyd A. Buras, Jr, Metairie LA
William Freeman, Prairieville LA
Lee Stevens, Bossier City LA
F. Jeff White, III, Shreverport LA

Louisiana State Medical Society

Delegate allocation for 2020: 6

Alternate Delegate(s)

William "Beau" Clark, Baton Rouge LA
Caleb Natale, New Orleans LA
Katherine Williams, Covington LA

Regional Medical Student Delegate(s)

Justin Magrath, New Orleans LA

Maine Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Richard A. Evans, Dover Foxcroft ME
Maroulla S. Gleaton, Palermo ME

Alternate Delegate(s)

Dieter Kreckel, Rumford ME
Amy Madden, Rome ME

Regional Medical Student Delegate(s)

Tyler Lang, ME

MedChi: The Maryland State Medical Society

Delegate allocation for 2020: 5

Delegate(s)

Harbhajan Ajrawat, Potomac MD
Loralie Dawn Ma, Fulton MD
Shannon Pryor, Chevy Chase MD
Stephen J. Rockower, Rockville MD
Bruce M. Smoller, Potomac MD

Alternate Delegate(s)

Renee Bovelle, Silver Spring MD
Brooke M. Buckley, Annapolis MD
Omar Harfouch, Baltimore MD
Gary Pushkin, Baltimore MD
Padmini Ranasinghe, Baltimore MD

Regional Medical Student Delegate(s)

Jack Gatti, Baltimore MD

Massachusetts Medical Society

Delegate allocation for 2020: 13

Delegate(s)

Maryanne C. Bombaugh, Falmouth MA
Theodore A. Calianos, II, Mashpee MA
Alain A. Chaoui, Boxford MA
Dennis Dimitri, Worcester MA
Henry Dorkin, Newton MA

Massachusetts Medical Society

Delegate allocation for 2020: 13

Delegate(s)

Ronald Dunlap, Weymouth MA
Melody J. Eckardt, Milton MA
McKinley Glover, Brookline MA
Lee S. Perrin, Southborough MA
Richard Pieters, Jr, Duxbury MA
David A. Rosman, Jamaica Plain MA
Spiro Spanakis, Shrewsbury MA
Lynda M. Young, Worcester MA

Alternate Delegate(s)

Carole Allen, Arlington MA
Nicolas Argy, Dartmouth MA
Emily Cleveland Manchanda, Roslindale MA
Christopher Garofalo, N Attleboro MA
Kathryn Hughes, Falmouth MA
Matthew Lecuyer, RI
Michael Medlock, Lexington MA
Samia Osman, Roxbury MA
Maximilian J. Pany, Lynn MA
Kenath Shamir, Fall River MA
Ellana Stinson, Boston MA
Carl Streed, Jr, Boston MA

Resident and Fellow Sectional Delegate(s)

Mark Kashtan, Boston MA

Resident and Fellow Sectional Alternate Delegate(s)

Caitlin Farrell, Northampton MA

Regional Medical Student Delegate(s)

Leah Yuan, Boston MA

Regional Medical Student Alternate Delegate(s)

Hussein Antar, Worcester MA
Amanda Whitehouse, MA

Michigan State Medical Society

Delegate allocation for 2020: 13

Delegate(s)

Mohammed A. Arsiwala, Livonia MI
Paul D. Bozyk, Beverly Hills MI
Michael D. Chafty, Kalamazoo MI
Betty S. Chu, Detroit MI
Pino D. Colone, Howell MI
Sarah A Gorgis, Sterling Heights MI

Michigan State Medical Society

Delegate allocation for 2020: 13

Delegate(s)

Mark C. Komorowski, Essexville MI
Rose M. Ramirez, Belmont MI
Venkat K. Rao, Grand Blanc MI
Michael A. Sandler, West Bloomfield MI
Krishna K. Sawhney, Bloomfield Hills MI
Richard E. Smith, Detroit MI
David T. Walsworth, East Lansing MI

Alternate Delegate(s)

Edward Bush, Grosse Ile MI
T. Jann Caison-Sorey, Bloomfield Heights M
Jayne E. Courts, Caledonia MI
Kenneth Elmassian, East Lansing MI
Amit Ghose, Okemos MI
Nabiha Hashmi, Troy MI
Theodore Jones, Dearborn MI
Patricia Kolowich, Northville MI
Christie L. Morgan, Grosse Pointe Woods MI
M. Salim U. Siddiqui, Canton MI
John A. Waters, Flint MI

Regional Medical Student Delegate(s)

Sameen Ansari, MI

Regional Medical Student Alternate Delegate(s)

Cynthia Kuk, Grand Rapids MI

Minnesota Medical Association

Delegate allocation for 2020: 5

Delegate(s)

John Abenstein, Oronoco MN
David L. Estrin, Plymouth MN
Paul C. Matson, Mankato MN
Cindy F. Smith, Spicer MN
David Thorson, Mahtomedi MN

Alternate Delegate(s)

Andrea Hillerud, MN
Dennis O'Hare, Minneapolis MN
Ashok Patel, Rochester MN
Laurel Ries, Saint Paul MN
Keith Stelter, Mankato MN

Resident and Fellow Sectional Delegate(s)

Christopher Wee, Rochester MN

Minnesota Medical Association

Delegate allocation for 2020: 5

Regional Medical Student Alternate Delegate(s)

Abby Solom, Plymouth MN

Mississippi State Medical Association

Delegate allocation for 2020: 3

Delegate(s)

Jennifer Bryan, Brandon MS
Sharon Douglas, Madison MS
J Clay Hays, Jr, Jackson MS

Alternate Delegate(s)

Randy Easterling, Vicksburg MS
Katherine Pannel, Oxford MS
Lee Voulters, Pass Christian MS

Missouri State Medical Association

Delegate allocation for 2020: 6

Delegate(s)

Elie Azrak, Saint Louis MO
Edmond Cabbabe, St Louis MO
James Conant, St. Joseph MO
Joseph Corrado, Mexico MO
Warren Lovinger, Nevada MO
Charles W. Van Way, Fairway KS

Alternate Delegate(s)

Peggy Barjenbruch, Mexico MO
Betty Drees, Kansas City MO
Alexander Hover, Jr, Springfield MO
Ravi S Johar, Chesterfield MO
Joanne Loethen, Prairie Village KS
Samantha Lund, Saint Louis MO

Montana Medical Association

Delegate allocation for 2020: 1

Delegate(s)

Carter E. Beck, Missoula MT

Alternate Delegate(s)

Nicole C. Clark, Helena MT

Nebraska Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Kelly J. Caverzagie, Omaha NE
Jordan Warchol, Elkhorn NE

Nebraska Medical Association

Delegate allocation for 2020: 2

Alternate Delegate(s)

Todd Hlavaty, North Platte NE

Regional Medical Student Delegate(s)

Rohan Khazanchi, Omaha NE

Nevada State Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Wayne C. Hardwick, Reno NV
Florence Jameson, Las Vegas NV

Alternate Delegate(s)

Joseph A. Adashek, Las Vegas NV
Peter R. Fenwick, Reno NV

Resident and Fellow Sectional Delegate(s)

Helene Nepomuceno, Las Vegas NV

Regional Medical Student Delegate(s)

Neha Agrawal, NV

Regional Medical Student Alternate Delegate(s)

Natasha McGlaun, Henderson NV

New Hampshire Medical Society

Delegate allocation for 2020: 1

Delegate(s)

William J. Kassler, Bedford NH

Alternate Delegate(s)

P. Travis Harker, Manchester NH

Medical Society of New Jersey

Delegate allocation for 2020: 8

Delegate(s)

Mary Campagnolo, Bordentown NJ
Joseph P. Costabile, Marlton NJ
Joseph J. Fallon, Jr, Marlton NJ
Charles Michael Moss, Ramsey NJ
Nancy L. Mueller, Englewood Cliffs NJ
John W. Poole, Ridgewood NJ
Niranjan V. Rao, Somerset NJ
David Swee, Highland Park NJ

Alternate Delegate(s)

Donald M. Chervenak, Florham Park NJ
Kennedy U. Ganti, Chesterfield NJ
Christopher Gribbin, Princeton NJ

Medical Society of New Jersey

Delegate allocation for 2020: 8

Alternate Delegate(s)

Nicole A. Henry-Dindial, Westfield NJ
Steven P. Shikiar, Englewood NJ

Resident and Fellow Sectional Alternate Delegate(s)

Harry Rockower, Camden NJ

Regional Medical Student Delegate(s)

Richard Saporito, Ho Ho Kus NJ

Regional Medical Student Alternate Delegate(s)

Eshani Dixit, New Brunswick NJ

New Mexico Medical Society

Delegate allocation for 2020: 2

Delegate(s)

Stephen P. Lucero, Taos NM
William Ritchie, Albuquerque NM

Alternate Delegate(s)

Dion Gallant, Albuquerque NM
Nancy Wright, Sapello NM

Regional Medical Student Delegate(s)

Sally Midani, Albuquerque NM

Medical Society of the State of New York

Delegate allocation for 2020: 22

Delegate(s)

Jerome C. Cohen, Loch Sheldrake NY
Frank G. Dowling, Islandia NY
Arthur C. Fougner, Little Neck NY
Kira Geraci-Ciardullo, Harrison NY
Robert B. Goldberg, Morristown NJ
Howard Huang, Watertown NY
Robert J. Hughes, Queensbury NY
John J. Kennedy, Schenectady NY
Andrew Y. Kleinman, Rye Brook NY
Daniel J. Koretz, Ontario NY
William R. Latreille, Malone NY
Bonnie L. Litvack, Mont Kisco NY
Thomas J. Madejski, Medina NY
Joseph R. Maldonado, Jr, Westernville NY
Leah S. Mc Cormack, Middletown NJ
Parag Mehta, New Hyde Park NY
Gregory L. Pinto, Saratoga Springs NY

Medical Society of the State of New York

Delegate allocation for 2020: 22

Delegate(s)

Malcolm D. Reid, Briarcliff Manor NY
Joseph Sellers, Cobleskill NY
Catherine Steger, Flushing NY
Corliss Varnum, Oswego NY
Daniel M. Young, Vesta NY

Alternate Delegate(s)

Mark Adams, Fairport NY
Louis Auguste, Manhasset NY
Maria Basile, Westhampton NY
Rose Berkun, NY
Michael Brisman, Old Westbury NY
Stephen Coccaro, Setauket NY
Joshua M. Cohen, New York NY
Joseph DiPoala, Jr, Victor NY
Robert A. Frankel, Brooklyn NY
David Jakubowicz, Scarsdale NY
Arjun Kumar, Kdw Gardens NY
Paul A. Pipia, Syosset NY
Barry Rabin, Syracuse NY
Abdul Rehman, Staten Island NY
Charles Rothberg, Patchogue NY
Richard Vienne, Williamsville NY

Resident and Fellow Sectional Delegate(s)

Christopher T. Clifford, New York NY

Regional Medical Student Delegate(s)

Parth Trivedi, New Hyde Park NY

Regional Medical Student Alternate Delegate(s)

Jess Hubert, Rochester NY

North Carolina Medical Society

Delegate allocation for 2020: 6

Delegate(s)

William E. Bowman, Greensboro NC
G Hadley Callaway, Raleigh NC
Mary Ann Contogiannis, Greensboro NC
John A. Fagg, Winston-Salem NC
Darlyne Menscer, Charlotte NC
Liana Puscas, Durham NC

Alternate Delegate(s)

E. Rebecca Hayes, Charlotte NC
Devdutta Sangvai, Durham NC

North Carolina Medical Society

Delegate allocation for 2020: 6

Resident and Fellow Sectional Alternate Delegate(s)

Karishma Hubba, Chapel Hill NC

Regional Medical Student Delegate(s)

Amber Gautam, Raleigh NC

Regional Medical Student Alternate Delegate(s)

Lauren Forbes, NC

North Dakota Medical Association

Delegate allocation for 2020: 1

Delegate(s)

Shari L. Orser, Bismarck ND

Alternate Delegate(s)

A. Michael Booth, Bismarck ND

Ohio State Medical Association

Delegate allocation for 2020: 13

Delegate(s)

Anthony Armstrong, Sylvania OH
Tyler J. Campbell, Winchester OH
Robyn F. Chatman, Cincinnati OH
Brett Coldiron, Cincinnati OH
Louito C. Edje, Maumee OH
Lisa Bohman Egbert, Kettering OH
Richard R. Ellison, Fairlawn OH
Gary R. Katz, Dublin OH
Deepak Kumar, Dayton OH
Andrew Rudawsky, Lakewood OH
William C. Sternfeld, Sylvania OH
Carl S. Wehri, Delphos OH
Regina Whitfield-Kekessi, Cincinnati OH

Alternate Delegate(s)

Bradley Christoph, Columbus OH
John Corker, Cincinnati OH
Meghan Lark, Sylvania OH
Shannon Trotter, Columbus OH
Colette R. Willins, Avon OH

Resident and Fellow Sectional Delegate(s)

Luke V. Selby, Columbus OH

Resident and Fellow Sectional Alternate Delegate(s)

Michael Villarreal, Columbus OH

Ohio State Medical Association

Delegate allocation for 2020: 13

Regional Medical Student Delegate(s)

Haidn Foster, Covington KY

Oklahoma State Medical Association

Delegate allocation for 2020: 4

Delegate(s)

Sherri Baker, Edmond OK
Jack J. Beller, Norman OK
Jay A. Gregory, Muskogee OK
Bruce Storms, Chickasha OK

Alternate Delegate(s)

Peter Aran, Tulsa OK
Larry Bookman, Oklahoma City OK
Woody Jenkins, Stillwater OK
Kevin Taubman, Tulsa OK

Regional Medical Student Delegate(s)

Samira Ali, Tulsa OK

Oregon Medical Association

Delegate allocation for 2020: 3

Delegate(s)

Peter A. Bernardo, Salem OR
Robert Dannenhoffer, Roseburg OR
Sylvia Ann Emory, Eugene OR

Alternate Delegate(s)

Kevin Ewanchyna, Corvallis OR
Mark Fischl, Salem OR

Pennsylvania Medical Society

Delegate allocation for 2020: 14

Delegate(s)

Theodore A. Christopher, Maple Glen PA
Michael A. DellaVecchia, Berwyn PA
James A. Goodyear, North Wales PA
Virginia E. Hall, Hummelstown PA
Marilyn J. Heine, Dresher PA
Bruce A. Mac Leod, Pittsburgh PA
Jill M. Owens, Bradford PA
Evan Jay Pollack, Bryn Mawr PA
Ralph Schmeltz, Pittsburgh PA
Scott E. Shapiro, Lower Gwynedd PA
John W. Spurlock, Bethlehem PA
Martin D. Trichtinger, Hatboro PA

Pennsylvania Medical Society

Delegate allocation for 2020: 14

Delegate(s)

John Michael Vasudevan, Philadelphia PA
John P. Williams, Gibsonia PA

Alternate Delegate(s)

Carrie DeLone, Camp Hill PA
Mark Friedlander, Narberth PA
Christopher Hughes, McMurray PA
F. Wilson Jackson, III, Camp Hill PA
Bindukumar Kansupada, Yardley PA
Lauren Kramer, Warminster PA
Chadd Kraus, Lewisburg PA
Peter S. Lund, Fairview PA
Dale M. Mandel, Philadelphia PA
Timothy Pelkowski, Erie PA
Shyama Sathianathan, Hershey PA
James W. Thomas, North Wales PA
Hans T. Zuckerman, Lebanon PA

Resident and Fellow Sectional Alternate Delegate(s)

Anupriya Dayal, Jenkintown PA
Elisa Giusto, Breinigsville PA

Regional Medical Student Delegate(s)

Samyuktha (Sami) Melachuri, Pittsburgh PA

Regional Medical Student Alternate Delegate(s)

Arshjot Khokhar, PA

Puerto Rico Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Yussef Galib-Frangie Fiol, San German PR
Gonzalo V. Gonzalez-Liboy, Carolina PR

Rhode Island Medical Society

Delegate allocation for 2020: 2

Delegate(s)

Alyn L. Adrain, Providence RI
Peter A. Hollmann, Cranston RI

Alternate Delegate(s)

E. Christine Brousseau, Cranston RI
Sarah Fessler, Riverside RI

South Carolina Medical Association

Delegate allocation for 2020: 5

Delegate(s)

Gary A. Delaney, Orangeburg SC
Richard Osman, Myrtle Beach SC
H Timberlake Pearce, Jr, Beaufort SC
Bruce A. Snyder, Greenville SC
Greg Tarasidis, Greenwood SC

Alternate Delegate(s)

Michael Finch, Jr, Columbia SC
Stephen Imbeau, Florence SC
Stefanie M. Putnam, Mauldin SC
Alexander Ramsay, Charleston SC
Todd E Schlesinger, Charleston SC

Regional Medical Student Delegate(s)

Dory Askins, Greenville SC
Tristan Mackey, Greenville SC

Regional Medical Student Alternate Delegate(s)

Daniel Lee, Greenville SC

South Dakota State Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Robert L. Allison, Pierre SD
Mary Carpenter, Winner SD

Alternate Delegate(s)

Benjamin Aaker, Yankton SD

Tennessee Medical Association

Delegate allocation for 2020: 5

Delegate(s)

Richard J. DePersio, Knoxville TN
Donald B. Franklin, Signal Mountain TN
John J. Ingram, III, Alcoa TN
James D. King, Selmer TN
Wiley T. Robinson, Memphis TN

Alternate Delegate(s)

VijayaLakshmi Appareddy, Chattanooga TN
O. Lee Berkenstock, Cordova TN
Nita Shumaker, Hixson TN
Richard G. Soper, Nashville TN
Christopher E. Young, Signal Mtn TN

Tennessee Medical Association

Delegate allocation for 2020: 5

Resident and Fellow Sectional Alternate Delegate(s)

Kelly Landeen, Nashville TN

Regional Medical Student Alternate Delegate(s)

Rocklin Shumaker, Johnson City TN

Texas Medical Association

Delegate allocation for 2020: 20

Delegate(s)

Michelle A. Berger, Austin TX
Brad G. Butler, Abilene TX
Gerald Ray Callas, Beaumont TX
Diana Fite, Magnolia TX
David C. Fleeger, Austin TX
William H. Fleming, III, Houston TX
Gary Floyd, Keller TX
John T. Gill, Dallas TX
William S. Gilmer, Houston TX
Robert T. Gunby, Jr, Dallas TX
David N. Henkes, San Antonio TX
Asa C. Lockhart, Tyler TX
Kenneth L. Mattox, Houston TX
Kevin H. McKinney, Galveston TX
Larry E. Reaves, Fort Worth TX
Leslie H. Secrest, Dallas TX
Jayesh Shah, San Antonio TX
Lyle S. Thorstenson, Nacogdoches TX
E. Linda Villarreal, Edinburg TX
Arlo F. Weltge, Bellaire TX

Alternate Delegate(s)

John T. Carlo, Dallas TX
Robert H. Emmick, Jr, Austin TX
John G. Flores, Carrollton TX
Gregory M. Fuller, Keller TX
Laura Faye Gephart, TX
Steven R. Hays, Dallas TX
Bryan G. Johnson, Frisco TX
Cynthia Jumper, Lubbock TX
Faith Mason, Galveston TX
Jennifer Rushton, San Antonio TX
Ezequiel "Zeke" Silva, III, San Antonio TX
Elizabeth Torres, Sugar Land TX

Texas Medical Association

Delegate allocation for 2020: 20

Alternate Delegate(s)

Roxanne Tyroch, El Paso TX
Sherif Z. Zaafran, Houston TX

Resident and Fellow Sectional Delegate(s)

Michael Metzner, San Antonio TX

Resident and Fellow Sectional Alternate Delegate(s)

Jerome Jeevarajan, Houston TX
M. Theresa Phan, Austin TX

Regional Medical Student Delegate(s)

James Bunch, Lubbock TX

Regional Medical Student Alternate Delegate(s)

Josh Bilello, Carrolton TX
Abnishek Dharan, El Paso TX
Rajadhar Reddy, Houston TX
Ikram Rostane, Missouri City TX

Utah Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Mark Bair, Highland UT
Patrice Hirning, Salt Lake City UT

Alternate Delegate(s)

Kerry Fisher, Salt Lake City UT
Richard Labasky, Sandy UT

Vermont Medical Society

Delegate allocation for 2020: 1

Delegate(s)

Norman Ward, Burlington VT

Alternate Delegate(s)

Catherine Schneider, Windsor VT

Medical Society of Virginia

Delegate allocation for 2020: 8

Delegate(s)

Claudette E. Dalton, Nellysford VA
Clifford L. Deal, III, Richmond VA
Randolph J. Gould, Virginia Beach VA
Edward G. Koch, McLean VA
Lawrence K. Monahan, Roanoke VA
Bhushan H. Pandya, Danville VA

Medical Society of Virginia

Delegate allocation for 2020: 8

Delegate(s)

Sterling N. Ransone, Jr, Cobbs Creek VA
William Reha, Woodridge VA

Alternate Delegate(s)

Joel Thomas Bundy, Virginia Beach VA
Alice Coombs-Tolbert, Richmond VA
Thomas W. Eppes, Jr, Forest VA
Michele A. Nedelka, Virginia Beach VA
Cynthia C. Romero, Virginia Beach VA

Resident and Fellow Sectional Delegate(s)

Joshua Lesko, Portsmouth VA

Regional Medical Student Delegate(s)

Meeta Prakash, Richmond VA

Regional Medical Student Alternate Delegate(s)

Matt Van De Graaf, Norfolk VA

Washington State Medical Association

Delegate allocation for 2020: 5

Delegate(s)

Matthew Grierson, Bothell WA
Erin Harnish, Longview WA
L Elizabeth Peterson, Spokane WA
Sheila D. Rege, Tri-Cities WA
Rod Trytko, Spokane WA

Alternate Delegate(s)

Peter J. Dunbar, Mercer Island WA
Nariman Heshmati, Mukliteo WA
Shane Macaulay, Bellevue WA

Resident and Fellow Sectional Delegate(s)

Elizabeth Parker, Seattle WA

West Virginia State Medical Association

Delegate allocation for 2020: 2

Delegate(s)

Hoyt Burdick, Huntington WV
Joseph Barry Selby, Morgantown WV

Alternate Delegate(s)

James D. Felsen, Great Cacapon WV
Ron Stollings, Madison WV
Sherri Young, Pinch WV

Wisconsin Medical Society

Delegate allocation for 2020: 5

Delegate(s)

George Melvin Lange, River Hills WI
Michael M. Miller, Madison WI
Charles J. Rainey, Milwaukee WI
Paul A. Wertsch, Madison WI
Tosha Wetterneck, Madison WI

Alternate Delegate(s)

Clarence P. Chou, Mequon WI
Nameeta Dookeran, Pawaukee WI
Barbara Hummel, Muskego WI
Don Lee, Franklin WI
Timothy G. Mc Avoy, Waukesha WI

Regional Medical Student Delegate(s)

Anna Heffron, Madison WI

Regional Medical Student Alternate Delegate(s)

Zach Dunton, Madison WI

Wyoming Medical Society

Delegate allocation for 2020: 1

Delegate(s)

Stephen Brown, Casper WY

Alternate Delegate(s)

Paul Johnson, Cheyenne WY

Academy of Physicians in Clinical Research

Delegate allocation for 2020: 1

Delegate(s)

Peter Howard Rheinstein, Severna Park MD

Alternate Delegate(s)

Michael Ybarra, Bethesda MD

Aerospace Medical Association

Delegate allocation for 2020: 1

Delegate(s)

Hernando J. Ortega, Jr, San Antonio TX

Alternate Delegate(s)

Daniel Shoor, San Antonio TX

Air Force

Delegate allocation for 2020: 1

Delegate(s)

Paul Friedrichs, Alexandria VA

AMDA-The Society for Post-Acute and Long-Term Care Medicine

Delegate allocation for 2020: 2

Delegate(s)

Rajeev Kumar, Oak Brook IL

Karl Steinberg, Oceanside CA

Alternate Delegate(s)

Walter Lin, Saint Louis MO

Wayne Saltsman, Burlington MA

American Academy of Allergy, Asthma & Immunology

Delegate allocation for 2020: 1

Delegate(s)

Steven G. Tolber, Corrales NM

Alternate Delegate(s)

Lynda G. Kabbash, Chestnut Hill MA

American Academy of Child and Adolescent Psychiatry

Delegate allocation for 2020: 2

Delegate(s)

David Fassler, Burlington VT

Louis Kraus, Northbrook IL

American Academy of Child and Adolescent Psychiatry

Delegate allocation for 2020: 2

Resident and Fellow Sectional Alternate Delegate(s)

Afifa Adiba, Wallingford CT

American Academy of Cosmetic Surgery

Delegate allocation for 2020: 1

Delegate(s)

Anthony J. Geroulis, Northfield IL

Alternate Delegate(s)

Robert F. Jackson, Noblesville IN

American Academy of Dermatology

Delegate allocation for 2020: 4

Delegate(s)

Hillary Johnson-Jahangir, Iowa City IA

Andrew P. Lazar, Washington DC

Marta Jane Van Beek, Iowa City IA

Cyndi J. Yag-Howard, Naples FL

Alternate Delegate(s)

Lindsay Ackerman, Phoenix AZ

Seemal Desai, Plano TX

Adam Rubin, Philadelphia PA

Sabra Sullivan, Jackson MS

American Academy of Facial Plastic and Reconstructive Surgery

Delegate allocation for 2020: 1

Delegate(s)

J Regan Thomas, Chicago IL

Alternate Delegate(s)

Paul J. Carniol, Summit NJ

American Academy of Family Physicians

Delegate allocation for 2020: 16

Delegate(s)

Joanna T. Bisgrove, Oregon WI

John Cullen, Valdez AK

Michael Hanak, LaGrange IL

Daniel Heinemann, Canton SD

American Academy of Family Physicians

Delegate allocation for 2020: 16

Delegate(s)

Tate Hinkle, Auburn AL

Jayaprada Kasaraneni, Odessa TX

Gary Le Roy, Dayton OH

Evelyn Lynnette Lewis, Newman GA

Ivonne McClean, Bronx NY

Stephen Richards, Spirit Lakes IA

Tyson Schwab, Bountiful UT

Ada Stewart, Columbia SC

Hugh Taylor, Hamilton MA

Morgan Weiler, Kansas City KS

Janet West, Jacksonville FL

J. Mack Worthington, Chattanooga TN

Alternate Delegate(s)

Emily Briggs, New Braunfels TX

Douglas E. Henley, Leawood KS

Anita Ravi, New York NY

Julie K. Wood, Leawood KS

Kim Yu, Novi MI

American Academy of Hospice and Palliative Medicine

Delegate allocation for 2020: 2

Delegate(s)

Ronald J. Crossno, Rockdale TX

Chad D. Kollas, Orlando FL

Alternate Delgate(s)

Phillip Peterson, Bluefield VA

American Academy of Insurance Medicine

Delegate allocation for 2020: 1

Delegate(s)

Deborah Y. Smart, Gurnee IL

Alternate Delegate(s)

Daniel George, Springfield MA

American Academy of Neurology

Delegate allocation for 2020: 4

Delegate(s)

Nicholas Johnson, Glen Allen VA

Shannon Kilgore, Palo Alto CA

Mark Milstein, New York NY

Jon Santoro, Santa Monica CA

Alternate Delegate(s)

Ann Murray, Morgantown WV

Eugene Scharf, Rochester MN

Cassie Williams, Charleston SC

Resident and Fellow Sectional Delegate(s)

Chelsea Stone, Redlands CA

Resident and Fellow Sectional Alternate Delegate(s)

Nikesh Bajaj, Phoenix AZ

American Academy of Ophthalmology

Delegate allocation for 2020: 4

Delegate(s)

Kevin T. Flaherty, Wausau WI

Ravi Goel, Cherry Hill NJ

Lisa Nijm, Warrenville IL

Mildred M G. Olivier, Arlington Heights IL

Alternate Delegate(s)

David W. Parke, II, San Francisco CA

Resident and Fellow Sectional Delegate(s)

Michelle Falcone, Miami FL

American Academy of Orthopaedic Surgeons

Delegate allocation for 2020: 5

Delegate(s)

John Early, Dallas TX

Heidi Hullinger, New York NY

Casey J. Humbyrd, Baltimore MD

William R. Martin, Chicago IL

Kimberly Jo Templeton, Leawood KS

Alternate Delegate(s)

Andrew W. Gurman, Altoona PA

William Shaffer, Washington DC

David Teuscher, Austin TX

American Academy of Otolaryngic Allergy

Delegate allocation for 2020: 1

Delegate(s)

Wesley Dean. VanderArk, Camp Hill PA

Alternate Delegate(s)

Robert Puchalski, Lugoff SC

American Academy of Otolaryngology-Head and Neck Surgery

Delegate allocation for 2020: 3

Delegate(s)

Craig Derkay, Norfolk VA

Susan Dixon McCammon, Birmingham AL

Douglas R. Myers, Vancouver WA

Alternate Delegate(s)

James C. Denneny, III, Alexandria VA

American Academy of Pain Medicine

Delegate allocation for 2020: 1

Delegate(s)

Robert Wailes, Carlsbad CA

Alternate Delegate(s)

Donna Bloodworth, Alvin TX

American Academy of Pediatrics

Delegate allocation for 2020: 5

Delegate(s)

Toluwalase Ajayi, San Diego CA

Charles Barone, Ira MI

Melissa J. Garretson, TX

Samantha Rosman, Jamaica Plain MA

David T. Tayloe, Jr, Goldsboro NC

Alternate Delegate(s)

Carol Berkowitz, Rancho Palos Verdes CA

Sara Goza, Fayetteville GA

Zarah Iqbal, San Francisco CA

Resident and Fellow Sectional Delegate(s)

Luis Seija, New York NY

Resident and Fellow Sectional Alternate Delegate(s)

Raymond Lorenzoni, New York NY

American Academy of Physical Medicine and Rehabilitation

Delegate allocation for 2020: 2

Delegate(s)

Stuart Glassman, Concord NH

Susan L. Hubbell, Lima OH

Alternate Delegate(s)

Carlo Milani, NY

Julie Ellen Witkowski, Rochester MN

American Academy of Psychiatry and the Law

Delegate allocation for 2020: 1

Delegate(s)

Barry Wall, Providence RI

Alternate Delegate(s)

Jennifer Piel, Seattle WA

American Academy of Sleep Medicine

Delegate allocation for 2020: 2

Delegate(s)

Alejandro Chediak, Coral Gables FL

Patrick J. Strollo, Gibsonia PA

Resident and Fellow Sectional Delegate(s)

Jessica Cho, Bronx NY

American Association for Geriatric Psychiatry

Delegate allocation for 2020: 2

Delegate(s)

Allan Anderson, Tucson AZ

Sandra Swantek, Chicago IL

American Association for Hand Surgery

Delegate allocation for 2020: 1

Delegate(s)

Peter C. Amadio, Rochester MN

Alternate Delegate(s)

Nicholas B. Vedder, Seattle WA

American Association for Thoracic Surgery

Delegate allocation for 2020: 1

Delegate(s)

Dan M. Meyer, Dallas TX

American Association of Clinical Endocrinologists

Delegate allocation for 2020: 2

Delegate(s)

Jonathan D. Leffert, Dallas TX

American Association of Clinical Urologists, Inc.

Delegate allocation for 2020: 1

Delegate(s)

Richard S. Pelman, Seattle WA

Alternate Delegate(s)

Martin Dineen, Dayton Beach FL

American Association of Gynecologic Laparoscopists

Delegate allocation for 2020: 3

Delegate(s)

Joseph M. Maurice, Chicago IL

American Association of Neurological Surgeons

Delegate allocation for 2020: 2

Delegate(s)

Kenneth S. Blumenfeld, Los Angeles CA

Joshua Rosenow, Chicago IL

Alternate Delegate(s)

Jason Schwalb, West Bloomfield MI

Krystal L. Tomei, Lyndhurst OH

American Association of Neuromuscular & Electrodiagnostic Medicine

Delegate allocation for 2020: 2

Delegate(s)

Enrica Arnaudo, Willmington DE

William Pease, Columbus OH

Alternate Delegate(s)

William S. David, Lincoln MA

American Association of Public Health Physicians

Delegate allocation for 2020: 1

Resident and Fellow Sectional Delegate(s)

Anna Yap, Los Angeles CA

American Clinical Neurophysiology Society

Delegate allocation for 2020: 1

Delegate(s)

Marc Nuwer, Los Angeles CA

Alternate Delegate(s)

Jaime Lopez, Stanford CA

American College of Allergy, Asthma and Immunology

Delegate allocation for 2020: 2

Delegate(s)

Alnoor A. Malick, Houston TX

Purvi Parikh, Bronx NY

Alternate Delegate(s)

John M. Seyerle, Cincinnati OH

American College of Cardiology

Delegate allocation for 2020: 7

Delegate(s)

Benjamin Galper, Potomac MD

Jerry D. Kennett, Columbia MO

M Eugene Sherman, Englewood CO

Suma Thomas, Cleveland OH

L. Samuel Wann, Whitefish Bay WI

Kim Allan Williams, Chicago IL

David Winchester, Gainesville FL

Alternate Delegate(s)

Nihar R Desai, New Haven CT

Aaron Kithcart, Boston MA

Jana E Montgomery, Merimack NH

American College of Emergency Physicians

Delegate allocation for 2020: 8

Delegate(s)

Nancy J. Auer, Mercer Island WA

Michael D. Bishop, Bloomington IN

Brooks F. Bock, Vail CO

Erick Eiting, New York NY

Stephen K Epstein, Boston MA

Hilary E. Fairbrother, Houston TX

John C. Moorhead, Portland OR

American College of Emergency Physicians

Delegate allocation for 2020: 8

Delegate(s)

Ashley Norse, Jacksonville FL

Alternate Delegate(s)

William Jaquis, Fort Lauderdale FL

Marc Mendelsohn, St. Louis MO

Reid Orth, Goldsboro NC

Debra Perina, Ruckersville VA

Resident and Fellow Sectional Delegate(s)

Scott Pasichow, Warwick RI

Resident and Fellow Sectional Alternate Delegate(s)

Sophia Spadafore, New York NY

American College of Legal Medicine

Delegate allocation for 2020: 1

Delegate(s)

Richard Wilbur, Lake Forest IL

Alternate Delegate(s)

Victoria L. Green, Stone Mountain GA

American College of Medical Genetics and Genomics

Delegate allocation for 2020: 1

Delegate(s)

Susan Debra Klugman, Bronx NY

Alternate Delegate(s)

Louanne Hudgins, Stanford CA

American College of Nuclear Medicine

Delegate allocation for 2020: 1

Delegate(s)

Alan Klitzke, Buffalo NY

American College of Obstetricians and Gynecologists

Delegate allocation for 2020: 13

Delegate(s)

Richard Allen, Portland OR

Dana Block-Abraham, Vienna VA

Cheryl Gibson Fountain, Grosse Pointe MI

Joseph M. Heyman, West Newbury MA

American College of Obstetricians and Gynecologists

Delegate allocation for 2020: 13

Delegate(s)

Nita Kulkarni, Flint MI

Mary E. LaPlante, Broadview Heights OH

G. Sealy Massingill, Fort Worth TX

Maureen Phipps, Providence RI

Diana Ramos, Laguna Beach CA

Brandi Ring, Denver CO

Kasandra Scales, Alexandria VA

Heather Smith, Newport RI

Robert Wah, McLean VA

Alternate Delegate(s)

Marygrace Elson, Iowa City IA

Coy Flowers, Roncerverte WV

Resident and Fellow Sectional Delegate(s)

Tani Malhotra, Westlake OH

Resident and Fellow Sectional Alternate Delegate(s)

Asha McClurg, Salt Lake City UT

American College of Occupational and Environmental Medicine

Delegate allocation for 2020: 2

Delegate(s)

Albert J. Osbahr, III, Hickory NC

Kenji Saito, Augusta ME

Alternate Delegate(s)

Allison Jones, Urbana IL

Douglas Martin, Sioux City IA

American College of Physicians

Delegate allocation for 2020: 24

Delegate(s)

Micah Beachy, Omaha NE

Sue Bornstein, Dallas TX

Sarah G. Candler, Houston TX

Elisa Choi, MA

Charles Cutler, Merion PA

Nitin S Damle, Wakefield RI

American College of Physicians

Delegate allocation for 2020: 24

Delegate(s)

Noel N. Deep, Antigo WI
Yul D. Ejnes, N Scituate RI
Jacqueline Fincher, Thomson GA
William E. Fox, Charlottesville VA
Richard S. Frankenstein, Tustin CA
Heather E. Gantzer, Minneapolis MN
William E. Golden, Little Rock AR
Arjun B. Gupta, New York NY
Tracey Henry, Powder Springs GA
Susan Hingle, Springfield IL
J Leonard Lichtenfeld, Atlanta GA
Suja M. Mathew, Chicago IL
Robert McLean, New Haven CT
Darilyn Moyer, Philadelphia PA
Avital O'Glasser, Portland OR
Jacob Quinton, Los Angeles CA
Christina M. Reimer, Tinmath CO
Donna E. Sweet, Wichita KS

Alternate Delegate(s)

Hanna Erickson, Urbana IL

American College of Preventive Medicine

Delegate allocation for 2020: 2

Delegate(s)

Wendy Braund, Pittsburgh PA
Robert Gilchick, Los Angeles CA

Alternate Delegate(s)

Andrew Karasick, Piscataway NJ
Jason M. Spangler, Arlington VA

American College of Radiology

Delegate allocation for 2020: 7

Delegate(s)

Bibb Allen, Jr, Mountain Brk AL
Tilden L. Childs, III, Fort Worth TX
Steven Falcone, Coral Springs FL
Todd M. Hertzberg, Pittsburgh PA

American College of Radiology

Delegate allocation for 2020: 7

Delegate(s)

Daniel H. Johnson, Jr, Metairie LA
Arl Van. Moore, Jr, Charlotte NC
Raymond Wynn, Burr Ridge IL

Alternate Delegate(s)

Naiim S. Ali, Burlington VT
Howard B. Fleishon, Norcross GA
Ami A. Shah, Brooklyn NY
Jessica Telleria, Chicago IL
Monica Wood, Cambridge MA

Resident and Fellow Sectional Delegate(s)

Gunjan Malhotra, Ann Arbor MI

Resident and Fellow Sectional Alternate Delegate(s)

Benjamin Meyer, Milwaukee WI

American College of Rheumatology

Delegate allocation for 2020: 2

Delegate(s)

Gary L. Bryant, Minnetonka MN
Eileen M. Moynihan, Hadden Heights NJ

Alternate Delegate(s)

Cristina G Arriens, Edmond OK
Colin Edgerton, Mt Pleasant SC

American College of Surgeons

Delegate allocation for 2020: 13

Delegate(s)

Daniel Dent, San Antonio TX
Jacob Moalem, Rochester NY
Leigh A. Neumayer, Tucson AZ
Naveen Sangji, Ann Arbor MI
Kenneth Sharp, Nashville TN
Patricia Turner, Chicago IL
Mark C. Weissler, Chapel Hill NC
Michael Zinner, Coral Gables FL

Alternate Delegate(s)

David B. Hoyt, Chicago IL

American College of Surgeons

Delegate allocation for 2020: 13

Resident and Fellow Sectional Delegate(s)

Usman Aslam, Arverne NY

Resident and Fellow Sectional Alternate Delegate(s)

Rachel Ekaireb, Sacramento CA

American Gastroenterological Association

Delegate allocation for 2020: 3

Delegate(s)

Claudia Gruss, Redding CT

American Geriatrics Society

Delegate allocation for 2020: 2

Delegate(s)

Eugene Lammers, Mobile AL

Craig Rubin, Dallas TX

Resident and Fellow Sectional Delegate(s)

Kieran Mc Avoy, Brookfield WI

American Institute of Ultrasound in Medicine

Delegate allocation for 2020: 2

Delegate(s)

David P. Bahner, Columbus OH

Marilyn Laughead, Scottsdale AZ

American Medical Group Association

Delegate allocation for 2020: 1

Delegate(s)

Lynn Vaughn Mitchell, Oklahoma City OK

American Medical Women's Association

Delegate allocation for 2020: 1

Delegate(s)

Nancy Church, Oak Lawn IL

Alternate Delegate(s)

Neelum Aggarwal, Chicago IL

American Orthopaedic Association

Delegate allocation for 2020: 1

Delegate(s)

Norman Chutkan, Phoenix AZ

American Orthopaedic Foot and Ankle Society

Delegate allocation for 2020: 1

Delegate(s)

Michael S. Aronow, West Hartford CT

Alternate Delegate(s)

Christopher Chiodo, Walpole MA

American Osteopathic Association

Delegate allocation for 2020: 1

Delegate(s)

Ronald R. Burns, Winter Park FL

Alternate Delegate(s)

William Sumners Mayo, Oxford MS

American Psychiatric Association

Delegate allocation for 2020: 9

Delegate(s)

Kenneth M. Certa, Plymouth Meeting PA

Frank Alexander Clark, Simpsonville SC

Jerry L. Halverson, Oconomowoc WI

Ray Hsiao, Bellevue WA

Theresa M. Miskimen, Millstone Twp NJ

Alternate Delegate(s)

Sara Coffey, Tulsa OK

Saul M. Levin, Washington DC

Paul O'Leary, Birmingham AL

Ravi Navin Shah, New York NY

Resident and Fellow Sectional Delegate(s)

Laura Halpin, Los Angeles CA

Resident and Fellow Sectional Alternate Delegate(s)

Karen Dionesotes, Baltimore MD

American Rhinologic Society

Delegate allocation for 2020: 1

Delegate(s)

Kevin (Chris) Mc Mains, San Antonio TX

Alternate Delegate(s)

Joshua M Levy, Atlanta GA

American Roentgen Ray Society

Delegate allocation for 2020: 3

Delegate(s)

Denise Collins, Detroit MI

Anton N. Hasso, Orange CA

American Society for Aesthetic Plastic Surgery

Delegate allocation for 2020: 1

Delegate(s)

Gary J. Price, Guilford CT

Alternate Delegate(s)

Michele Manahan, Baltimore MD

American Society for Clinical Pathology

Delegate allocation for 2020: 3

Delegate(s)

Edmund R. Donoghue, Jr, Pooler GA

David Lewin, Charleston SC

James L. Wisecarver, Omaha NE

Alternate Delegate(s)

William G. Finn, Ann Arbor MI

Steven H. Kroft, Mequion WI

Jennifer Nicole Stall, Minneapolis MN

Resident and Fellow Sectional Alternate Delegate(s)

Anne Chen, Redwood City CA

American Society for Dermatologic Surgery Association

Delegate allocation for 2020: 2

Delegate(s)

Jessica Krant, NY

Anthony Rossi, Jr, New York NY

Alternate Delegate(s)

M. Laurin Council, Saint Louis MO

Chad Prather, Baton Rouge LA

American Society for Gastrointestinal Endoscopy

Delegate allocation for 2020: 2

Delegate(s)

Robin Mendelsohn, New York NY

American Society for Gastrointestinal Endoscopy

Delegate allocation for 2020: 2

Delegate(s)

Walter G. Park, Los Altos CA

American Society for Metabolic and Bariatric Surgery

Delegate allocation for 2020: 1

Delegate(s)

John Scott, Greenville SC

Alternate Delegate(s)

Christopher Joyce, New Lenox IL

American Society for Radiation Oncology

Delegate allocation for 2020: 2

Delegate(s)

Shane Hopkins, Ames IA

Shilpen A. Patel, Redwood CA

Resident and Fellow Sectional Delegate(s)

Ankit Agarwal, Chapel Hill NC

American Society for Reconstructive Microsurgery

Delegate allocation for 2020: 1

Delegate(s)

Gregory R. Evans, Orange CA

Alternate Delegate(s)

Lawrence J. Gottlieb, Chicago IL

American Society for Reproductive Medicine

Delegate allocation for 2020: 2

Delegate(s)

Albert Hsu, Columbia MO

Rashmi Kudesia, Houston TX

Alternate Delegate(s)

Hugh Taylor, Ipswich MA

American Society for Surgery of the Hand

Delegate allocation for 2020: 1

Delegate(s)

David Lichtman, Ft Worth TX

Alternate Delegate(s)

Robert C. Kramer, Beaumont TX

American Society of Addiction Medicine

Delegate allocation for 2020: 2

Delegate(s)

Stuart Gitlow, New York NY

Ilse R. Levin, Silver Spring MD

Alternate Delegate(s)

Kelly J Clark, Louisville KY

American Society of Anesthesiologists

Delegate allocation for 2020: 7

Delegate(s)

Randall M. Clark, Denver CO

James D. Grant, Bloomfield Hills MI

Ronald Harter, Dublin OH

Tripti C. Kataria, Chicago IL

Candace E. Keller, Miramar Beach FL

Michael B. Simon, Wappingers Falls NY

Gary D. Thal, Chicago IL

Alternate Delegate(s)

Jennifer Bartlotti-Telesz, Temecula CA

Padma Gulur, Chapel Hill NC

Mary Dale Peterson, Corpus Christi TX

Crystal C. Wright, Houston TX

Resident and Fellow Sectional Alternate Delegate(s)

Jayme Looper, Gainesville FL

American Society of Breast Surgeons

Delegate allocation for 2020: 2

Delegate(s)

Steven Chen, San Diego CA

American Society of Cataract and Refractive Surgery

Delegate allocation for 2020: 2

Delegate(s)

Parag D. Parekh, Dubois PA

American Society of Colon and Rectal Surgeons

Delegate allocation for 2020: 1

Delegate(s)

Harry Papaconstantinou, Temple TX

Alternate Delegate(s)

Ronald Gagliano, Phoenix AZ

American Society of Cytopathology

Delegate allocation for 2020: 1

Delegate(s)

Swati Mehrotra, Schaumburg IL

Alternate Delegate(s)

Tatjana Antic, Chicago IL

American Society of Dermatopathology

Delegate allocation for 2020: 1

Delegate(s)

Melissa Piliang, Cleveland OH

Alternate Delegate(s)

Karl Napekoski, Naperville IL

American Society of Echocardiography

Delegate allocation for 2020: 2

Delegate(s)

Kameswari Maganti, Chicago IL

Peter S. Rahko, Madison WI

American Society of General Surgeons

Delegate allocation for 2020: 1

Delegate(s)

Albert M. Kwan, Clovis NM

American Society of Hematology

Delegate allocation for 2020: 2

Delegate(s)

Chancellor Donald, New Orleans LA

American Society of Interventional Pain Physicians

Delegate allocation for 2020: 2

Delegate(s)

Sachin Jha, Tustin CA

Lee Snook, Sacramento CA

American Society of Maxillofacial Surgeons

Delegate allocation for 2020: 1

Delegate(s)

Kant Lin, Charlottesville VA

Alternate Delegate(s)

Victor L. Lewis, Jr, Chicago IL

American Society of Neuroimaging

Delegate allocation for 2020: 1

Delegate(s)

Ryan Hakimi, Greenville SC

Alternate Delegate(s)

Marc Malkoff, Memphis TN

American Society of Neuroradiology

Delegate allocation for 2020: 1

Delegate(s)

Jacqueline Anne Bello, New York NY

Alternate Delegate(s)

Jack Farinhas, Tampa FL

American Society of Ophthalmic Plastic and Reconstructive Surgery

Delegate allocation for 2020: 1

Delegate(s)

Erin Shriver, Iowa City IA

American Society of Plastic Surgeons

Delegate allocation for 2020: 2

Delegate(s)

Robert J. Havlik, WI

Lynn LC. Jeffers, Camarillo CA

Alternate Delegate(s)

Raj Ambay, Wesley Chapel FL

C. Bob Basu, Cypress TX

Resident and Fellow Sectional Delegate(s)

Danielle Rochlin, Stanford CA

Resident and Fellow Sectional Alternate Delegate(s)

Aaron Kearney, Chicago IL

American Society of Retina Specialists

Delegate allocation for 2020: 2

Delegate(s)

Michael J. Davis, Los Angeles CA

Joe Nezgoda, Jr, West Palm Beach FL

American Society of Transplant Surgeons

Delegate allocation for 2020: 1

Delegate(s)

Thomas G. Peters, Jacksonville FL

Alternate Delegate(s)

Stuart M. Greenstein, Bronx NY

American Thoracic Society

Delegate allocation for 2020: 3

Delegate(s)

Ajanta Patel, Chicago IL

Ai-Yui Maria Tan, Chicago IL

Chris Worsham, Charlestown MA

American Urological Association

Delegate allocation for 2020: 2

Delegate(s)

Hans C. Arora, Cleveland OH

Terrence Robert Grimm, Lexington KY

Alternate Delegate(s)

James H. Gilbaugh, Wichita KS

Jason Jameson, Phoenix AZ

Resident and Fellow Sectional Delegate(s)

Ruchika Talwar, Philadelphia PA

American Vein and Lymphatic Society

Delegate allocation for 2020: 1

Delegate(s)

Christopher Pittman, Tampa FL

Alternate Delegate(s)

Vineet Mishra, San Diego CA

AMSUS The Society of Federal Health Professionals

Delegate allocation for 2020: 2

Delegate(s)

John Cho, Fairfax VA

Army

Delegate allocation for 2020: 1

Delegate(s)

Kent DeZee, Bethesda MD

Association for Clinical Oncology

Delegate allocation for 2020: 3

Delegate(s)

Edward P. Balaban, Penllynn PA

Thomas A. Marsland, Petaluma CA

Ray D. Page, Fort Worth TX

Alternate Delegate(s)

Steve Y. Lee, Oakland CA

Kristina Novick, Rochester NY

Erin Schwab, Grand Rapids MI

Association of University Radiologists

Delegate allocation for 2020: 1

Delegate(s)

Stephen Chan, Closter NJ

Alternate Delegate(s)

Shyam Sabat, Hershey PA

College of American Pathologists

Delegate allocation for 2020: 4

Delegate(s)

James L. Caruso, Castle Rock CO

William V. Harrer, Haddonfield NJ

Jonathan Myles, Solon OH

Mark S. Synovec, Topeka KS

Alternate Delegate(s)

Jean Elizabeth Forsberg, Pineville LA

Donald Karcher, Washington DC

Joseph Sanfrancesco, Charleston SC

Susan Strate, Wichita Falls TX

Congress of Neurological Surgeons

Delegate allocation for 2020: 2

Delegate(s)

Jeffrey Cozzens, Springfield IL

Ann R. Stroink, Bloomington IL

Congress of Neurological Surgeons

Delegate allocation for 2020: 2

Alternate Delegate(s)

Maya A. Babu, Eagan MN

Endocrine Society, The

Delegate allocation for 2020: 2

Delegate(s)

Amanda Bell, Kansas City MO

Palak U. Choksi, Ann Arbor MI

Alternate Delegate(s)

Barbara Onumah, Bowie MD

Daniel Spratt, Portland ME

GLMA: Health Professionals Advancing LGBT Equality

Delegate allocation for 2020: 1

Delegate(s)

Jeremy Toler, New Orleans LA

Alternate Delegate(s)

Desiray C. Bailey, Des Moines WA

Heart Rhythm Society

Delegate allocation for 2020: 2

Delegate(s)

Jim Cheung, New York NY

Steve Hao, San Francisco CA

Alternate Delegate(s)

Timothy Larsen, Chicago IL

Infectious Diseases Society of America

Delegate allocation for 2020: 2

Delegate(s)

Michael L. Butera, San Diego CA

Steven W. Parker, Reno NV

Alternate Delegate(s)

Nancy Crum-Cianflone, Poway CA

Resident and Fellow Sectional Delegate(s)

Megan Srinivas, Fort Dodge IA

Resident and Fellow Sectional Alternate Delegate(s)

Nathanial Nolan, University City MO

International College of Surgeons-US Section

Delegate allocation for 2020: 1

Delegate(s)

Raymond A. Dieter, Jr, Glen Ellyn IL

Alternate Delegate(s)

Joshua Mammen, Leawood KS

International Society for the Advancement of Spine Surgery

Delegate allocation for 2020: 1

Delegate(s)

Morgan P. Lorio, Nashville TN

Alternate Delegate(s)

David Polly, Minneapolis MN

International Society of Hair Restoration Surgery

Delegate allocation for 2020: 1

Delegate(s)

Carlos J. Puig, Houston TX

Alternate Delegate(s)

Ricardo Mejia, Jupiter FL

National Association of Medical Examiners

Delegate allocation for 2020: 1

Delegate(s)

Michelle Jorden, San Jose CA

Alternate Delegate(s)

J Scott. Denton, Bloomington IL

National Medical Association

Delegate allocation for 2020: 1

Delegate(s)

Sandra L. Gadson, Merrillville IN

Alternate Delegate(s)

Gary Dennis, Frisco TX

Navy

Delegate allocation for 2020: 1

Delegate(s)

James L Hancock, Fairfax VA

Alternate Delegate(s)

Joel Schofer, Chesapeake VA

North American Neuromodulation Society

Delegate allocation for 2020: 1

Delegate(s)

Haroon I. Hameed, Washington DC

Alternate Delegate(s)

Nameer R. Haider, New Hartford NY

North American Neuro-Ophthalmology Society

Delegate allocation for 2020: 1

Delegate(s)

Thomas R. Mizen, Chicago IL

Alternate Delegate(s)

Nicholas Volpe, Chicago IL

North American Spine Society

Delegate allocation for 2020: 2

Delegate(s)

R Dale Blasier, Little Rock AR

William Mitchell, Mount Laurel NJ

Obesity Medicine Association

Delegate allocation for 2020: 1

Delegate(s)

Ethan Lazarus, Lone Tree CO

Alternate Delegate(s)

Anthony Auriemma, Elmhurst IL

Radiological Society of North America

Delegate allocation for 2020: 3

Delegate(s)

Michael C. Brunner, Madison WI

Kevin C. Reilly, Sr, Elizabethtown KY

Laura E. Traube, San Luis Obispo CA

Alternate Delegate(s)

Shadi Abdar Esfahani, Boston MA

Nandini (Nina) M. Meyersohn, Cambridge MA

Renal Physicians Association

Delegate allocation for 2020: 2

Delegate(s)

Louis H. Diamond, Rockville MD

Rebecca Schmidt, Morgantown WV

Society for Cardiovascular Angiography and Interventions

Delegate allocation for 2020: 1

Delegate(s)

J. Jeffrey Marshall, Atlanta GA

Alternate Delegate(s)

Osvaldo Steven Gigliotti, Austin TX

Society for Investigative Dermatology

Delegate allocation for 2020: 1

Delegate(s)

Daniel Bennett, Madison WI

Alternate Delegate(s)

Erica Dommasch, Boston MA

Society for Vascular Surgery

Delegate allocation for 2020: 2

Delegate(s)

Timothy F. Kresowik, Iowa City IA

Nicolas J. Mouawad, Bay City MI

Society of American Gastrointestinal Endoscopic Surgeons

Delegate allocation for 2020: 2

Delegate(s)

Kevin Reavis, Portland OR

Paresh Shah, New York NY

Society of Critical Care Medicine

Delegate allocation for 2020: 3

Delegate(s)

Kathleen Doo, Oakland CA

Russell C. Raphaely, Wilmington DE

Tina R. Shah, Atlanta GA

Alternate Delegate(s)

Josh Kayser, Philadelphia PA

Natalia Solenkova, Aventura FL

Society of Nuclear Medicine and Molecular Imaging

Delegate allocation for 2020: 1

Delegate(s)

Gary L. Dillehay, Chicago IL

Society of Nuclear Medicine and Molecular Imaging

Delegate allocation for 2020: 1

Alternate Delegate(s)

Hazem H. Chehabi, Newport Beach CA

Spine Intervention Society

Delegate allocation for 2020: 1

Delegate(s)

William D. Mauck, Rochester MN

Alternate Delegate(s)

Kate Sully, Niceville FL

The Society of Laparoscopic and Robotic Surgeons

Delegate allocation for 2020: 2

Delegate(s)

Camran Nezhat, Palo Alto CA

Triological Society, The

Delegate allocation for 2020: 1

Delegate(s)

Michael E. Hoffer, Miami FL

Undersea and Hyperbaric Medical Society

Delegate allocation for 2020: 1

Delegate(s)

Laurie Gesell, Brookfield WI

US and Canadian Academy of Pathology

Delegate allocation for 2020: 2

Delegate(s)

Nicole Riddle, Tampa FL

Daniel Zedek, Chapel Hill NC

Alternate Delegate(s)

Keagan H. Lee, Austin TX

Nirali M. Patel, Chicago IL

US Public Health Service

Delegate allocation for 2020: 1

Delegate(s)

Jerome Adams,

Alternate Delegate(s)

Brian M Lewis, Potomac MD

Veterans Affairs

Delegate allocation for 2020: 1

Delegate(s)

Carolyn M. Clancy, Silver Spring MD

Academic Physicians Section

Delegate allocation for 2020: 1

Delegate(s)

Kenneth B. Simons, Mequon WI

Alternate Delegate(s)

Alma B. Littles, Tallahassee FL

Integrated Physician Practice Section

Delegate allocation for 2020: 1

Delegate(s)

Russell C. Libby, Fairfax VA

International Medical Graduates Section

Delegate allocation for 2020: 1

Delegate(s)

Col. Ronit Katz, Cupertino CA

Alternate Delegate(s)

Kamalika Roy, Wilsonville OR

Medical Student Section

Delegate allocation for 2020: 1

Delegate(s)

Adam Panzer, Denver CO

Alternate Delegate(s)

Nathan J Carpenter, Milwaukee WI

Minority Affairs Section

Delegate allocation for 2020: 1

Delegate(s)

Dionne Hart, Rochester MN

Alternate Delegate(s)

Siobhan Wescott, Grand Forks ND

Organized Medical Staff Section

Delegate allocation for 2020: 1

Delegate(s)

Matthew Gold, Winchester MA

Alternate Delegate(s)

Raj B. Lal, Oakbrook IL

Resident and Fellow Section

Delegate allocation for 2020: 1

Delegate(s)

Amar Kelkar, Gainesville FL

Alternate Delegate(s)

Christopher Libby, Gainesville FL

Senior Physicians Section

Delegate allocation for 2020: 1

Delegate(s)

Barbara S. Schneidman, Seattle WA

Alternate Delegate(s)

Luis T. Sanchez, Newtonville MA

Women Physicians Section

Delegate allocation for 2020: 1

Delegate(s)

Josephine Nguyen, Vernon Hills IL

Alternate Delegate(s)

Nicole L. Plenty, Katy TX

Young Physicians Section

Delegate allocation for 2020: 1

Delegate(s)

Kavita Arora, Cleveland Heights OH

Alternate Delegate(s)

Alisha Reiss, Greenville OH

MEMBERS OF REFERENCE COMMITTEE F AND AMENDMENTS TO CONSTITUTION AND BYLAWS (JUNE 2020)

Ann R. Stroink, MD, Congress of Neurological Surgeons, Chair

Jerry P. Abraham, MD, MPH, California

David J. Bensema, MD, Kentucky

Michael D. Chafty, MD, JD, Michigan

Lynda G. Kabbash, MD, American Academy of Allergy, Asthma & Immunology*

Candace E. Keller, MD, MPH, American Society of Anesthesiologists

A. Lee Morgan, MD, Colorado

* *Alternate Delegate*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
Sunday, June 7, 2020
2:00 PM (CT)

1. Call to Order by the Speaker
2. Invocation & National Anthem
3. Report of the Committee on Rules and Credentials
4. Remarks of the Speaker
5. Address of the AMA President
6. Nominations of Officers and Councils

   Nomination of new member of Council on Ethical & Judicial Affairs
7. Board and Council Elections
8. Presentation, Correction and Adoption of Minutes of the 2019 Interim Meeting
9. Nominations for Distinguished Service Award
10. Report of Reference Committee F and Amendments to Constitution and Bylaws
11. AMA Presidential Inauguration and Address
12. Unfinished Business
13. Final Report of the Committee on Rules and Credentials

Reference Committee F and Amendments to Constitution and Bylaws

BOT Report(s)

01 Annual Report
02 New Specialty Organizations Representation in the House of Delegates
03 AMA 2021 Dues
04 Council on Legislation Sunset Review of 2008 and 2010 House Policies

CEJA Report(s)

01 Council on Ethical and Judicial Affairs Sunset Review of 2010 House Policies

CME Report(s)

01 Council on Medical Education Sunset Review of 2010 House Policies

CMS Report(s)

01 Council on Medical Service Sunset Review of 2010 House Policies

CSAPH Report(s)

01 Council on Science and Public Health Sunset Review of 2010 House Policies

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1, June 2020

Subject:	Annual Report
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

The Consolidated Financial Statements for the years ended December 31, 2019 and 2018 and the Independent Auditor's report have been included in a separate booklet, titled "2019 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

AMA
AMERICAN MEDICAL ASSOCIATION

PHYSICIANS' POWERFUL ALLY IN PATIENT CARE™

2019 ANNUAL REPORT

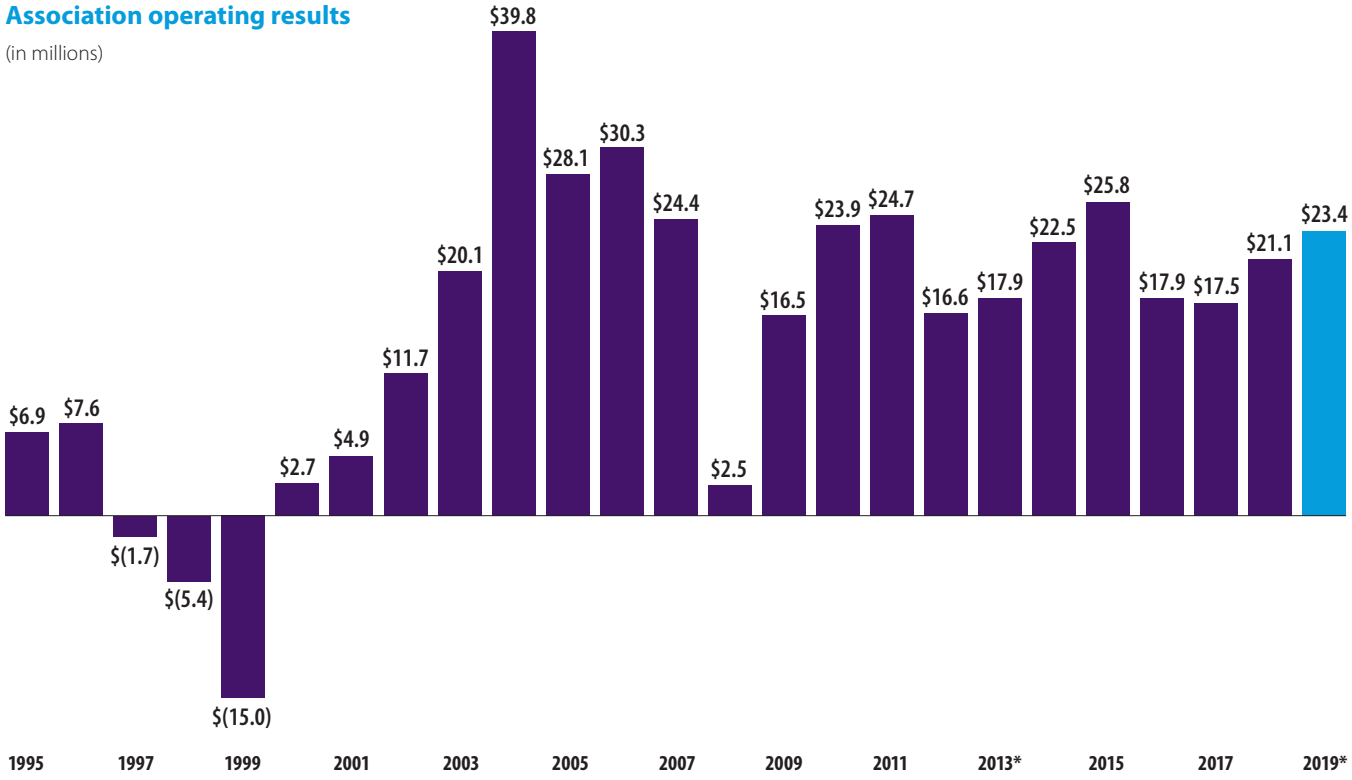
Financial highlights

(Dollars in millions)	2019	2018
Revenues	$ 392.3	$ 361.3
Cost of products sold and selling expense	27.8	27.7
General and administrative expenses, excluding pension termination expense	335.3	307.4
Pro forma operating results*	23.4	21.1
Pension termination expense	(36.2)	-
Non-operating items	75.2	(39.7)
Defined benefit postretirement plan non-service periodic expense	(3.9)	(3.1)
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	17.0	10.8
Change in unrestricted equity	75.5	(10.9)
Change in donor restricted equity	(0.1)	-
Change in association equity	$75.4	$ (10.9)
Association equity at year-end	$624.2	$ 548.8
Employees at year-end	1,146	1,087

**Excluding $36.2 million in noncash pension termination expense reclassified from non-operating expense*

Association operating results

(in millions)



**Pro forma operating results: 1) 2013 excludes $33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes $36.2 million noncash pension termination expense reclassification from non-operating results*

Letter to stakeholders

Physicians are valued and trusted allies in efforts to improve public health, especially at a time of heightened uncertainty, when misinformation and half-truths can spread globally in the blink of an eye.

We have earned our patients' trust through our dedication to science and evidence, through our honesty and our compassion, three elements that give meaning to our work as physicians and as leaders in medicine.

In 2019, the American Medical Association once again demonstrated why physicians look to us to be their powerful ally in patient care. Below and throughout the following pages you'll see examples of how we continue to:

- **Represent physicians with a unified voice**
- **Remove obstacles that interfere with patient care**
- **Lead the charge on confronting today's public health crises**
- **Drive the future of medicine**

The AMA advocated for patients by calling out technology companies for lax enforcement of e-cigarette advertising and by urging a federal ban on flavored smoking devices to stem the dramatic surge in youth smoking and prevent another generation from falling victim to nicotine addiction.

We protected the rights of patients through the courts in North Dakota and Oregon, defending freedom of speech between patients and physicians in two closely watched legal cases.

The AMA pushed for policy changes to reduce administrative burdens on physicians that so often undermine patient care. We advocated to the Centers for Medicare & Medicaid Services, and achieved the first overhaul of Evaluation & Management reporting and coding guidelines in more than 25 years.

We led the national effort to "right-size" the cumbersome prior authorization process that can jeopardize patient care, building industry consensus and backing legislation to streamline the process at the federal level and advance reforms in more than 15 states.

The AMA continued its national leadership on opioids, helping remove prior authorization for medication-assisted treatment for patients struggling with an opioid use disorder in 14 states and Washington, D.C. In addition, we launched a national road map that includes policy recommendations and best practices to help states more effectively respond to the epidemic.

At the same time, AMA's reach expanded to new frontiers and audiences. The JAMA Network—a consortium of publications that includes JAMA Network's preeminent flagship Journal and specialty journals—grew its multimedia content to include new videos, podcasts and visual abstracts. Downloads across the network exceeded 130 million in 2019.

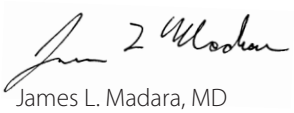
The AMA Ed Hub™, our new online physician education platform, drew more than 43,000 users in its first full year of operation in 2019, and the AMA created more than a dozen practice resources and tools for physicians to ease the transition to a value-based care health system.

This work was made possible thanks to another strong financial performance in 2019 and increased membership for the ninth year in a row. Fueled by our "Members Move Medicine" campaign that showcases individual physician leaders, AMA membership grew by three percent in 2019.

Results like these underscore the AMA's position as a recognized leader throughout health care, working collaboratively and with great purpose to create a health system that works better for patients, physicians and the nation.

Jesse M. Ehrenfeld, MD, MPH
Chair, Board of Trustees

S. Bobby Mukkamala, MD
Finance Committee Chair, Board of Trustees



James L. Madara, MD
Executive Vice President and Chief Executive Officer

ALLY TO PHYSICIANS

The AMA successfully urged CMS to adopt new physician payment models, including a set of primary care payment models and a model on emergency services, to **help ease the transition to value-based care**.

CMS implemented the Current Procedural Terminology (CPT®) framework to simplify documentation and coding of office visits—as well as other regulatory changes championed by the AMA—**further reducing administrative burdens and paperwork**.

Tamaan Osbourne-Roberts, MD, member since 2003

The AMA brought to a close the four-year, grant-funded Transforming Clinical Practice Initiative, which supported more than 140,000 physician practices and resulted in 20 new AMA STEPS Forward™ modules to **help practices share and implement evidence-based quality improvement strategies**.

We launched the Practice Transformation Initiative, partnering with state medical societies to recruit health systems and practice sites for field testing, gathering research and accelerating innovations to **improve physician satisfaction**.

We expanded our certification and licensure offerings in our online education delivery system, AMA Ed Hub™, to automatically transmit completed CME activities from the American Board of Pediatrics, American Board of Otolaryngology and select state medical boards.

The AMA awarded the first 11 grants through our Reimaging Residency Initiative, a five-year, $15-million grant program that builds on our Accelerating Change in Medical Education program by supporting innovations that will **provide meaningful and safe transitions from undergraduate to graduate medical education**.

Siobhan Wescott, MD, member since 2013

We kept physicians and medical students informed on the issues, such as the Title X lawsuit and the E/M rule change through AMA Morning Rounds and AMA social media. We also launched content by leveraging several new channels, such as Apple News, podcasts, Alexa skill and *AMA Moving Medicine*, our magazine focused on how the AMA and its members impact medicine.

We launched our Health Systems Science Learning Series and our Health Systems Science Scholars Program, **ensuring future physicians are well-equipped to care for patients in a modern health system**.

TRUSTED BY PATIENTS

We were among the **leading voices nationally calling for regulation of e-cigarettes and vaping devices** by the U.S. Federal Drug Administration and urging physicians to make sure their patients were aware of the dangers posed by these new products.

AMA convened thought leaders with diverse expertise for a discussion about **surveillance and data sharing** to inform targeted drug-related prevention, treatment, policymaking and harm-reduction strategies industrywide.

Druv Bhagavan, member since 2017

The AMA **protected patients from unanticipated medical bills** by working with state medical associations and national medical specialty societies to craft a common set of policies to guide advocacy efforts on surprise billing. We also worked to ensure surprise billing legislation passed by Congress holds patients harmless for unanticipated medical bills and limited out-of-pocket expenses.

We launched an Enterprise Social Responsibility program to engage AMA employees in public service work aligned with the organization's values and goals. **Employees logged nearly 2,400 volunteer hours in the program's first seven months, supporting more than 70 charities** in Chicago, Washington, D.C., and South Carolina.

The AMA partnered with the American Heart Association on a new **e-learning module on proper blood pressure measurement**, following results of a joint survey highlighting the need for such additional education.

We expanded our **M.A.P. Blood Pressure program** with 25 additional health care organizations and more than 100 pilot sites that provide care for nearly one million patients with hypertension.

Louito C. Edje, MD, member since 1992

As part of our national push for common-sense gun laws, the AMA urged Congress to earmark spending for gun violence research and prevention. Congress ultimately did so, dedicating **$25 million for gun violence research** for the first time in more than 20 years.

RESPECTED BY THE PROFESSION

We **expanded our reach in digital health**, working to scale solutions that are validated, effective and trusted through focused research and practice resources, such as the AMA Digital Health Implementation Playbook.

Our online digital health collaborative, the Physician Innovation Network, grew to more than 10,000 users and 20 partner organization across the industry, **leveraging physician experience and expertise in the design of new digital heal technologies**.

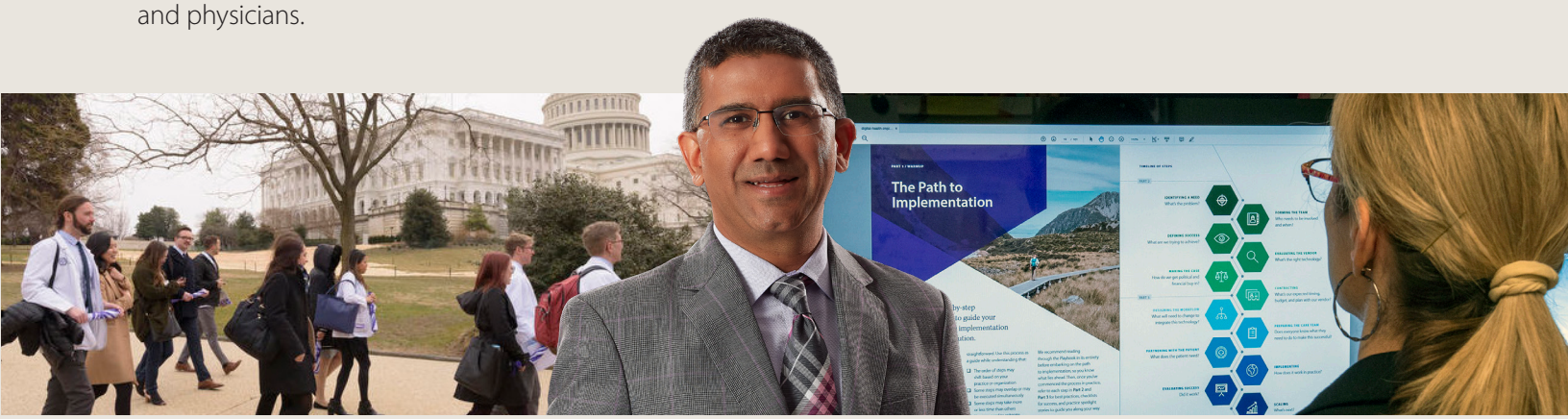
Emily Cleveland-Manchanda, MD, member since 2009

We established the AMA Center for Health Equity as the operational home to **build, drive and sustain health equity efforts across the organization and our health system**. The center has begun to build important relationships that will be critical in enabling the AMA's work to improve health outcomes, close disparities gaps and advance equity in medicine.

The startup we co-founded, Xcertia, **released and widely circulated industry standards** for the privacy, security, operability, content and usability of digital health applications.

The Current Procedural Terminology (or CPT®) Editorial Panel and AMA-convened Digital Medicine Payment Advisory Group advanced coverage and payment for digital medicine services by **establishing new codes for remote self-measure blood pressure monitoring e-visits** between patients and physicians.

We positioned the AMA's Integrated Health Model Initiative as a key stakeholder in data interoperability by receiving founding-member status in the Gravity Project, the **leading collaborative responsible for developing Social Determinants of Health data standards under HL7**.



Ravi Goel, MD, member since 1994

We **invested in the physician leaders of tomorrow** by bringing 400 medical students to Capitol Hill to meet with government leaders; by bringing together our AMA Board of Trustee members with more than 450 medical students at 30 medical schools; and by adding 10 new leadership positions at the AMA and developing a new leadership certificate program.

2019 MANAGEMENT'S DISCUSSION AND ANALYSIS

Management's discussion and analysis

Columnar and chart amounts in millions

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. Our focus is on our strategic arcs of addressing chronic disease, professional development and removing obstacles in health care, with health equity, advocacy and innovation supporting work across all arcs.

In 2019, AMA continued to maintain its focus on Practice Sustainability and Professional Satisfaction (PS2), expanding our research of credible practice science and working with physicians to advance initiatives that will help them navigate and succeed in a continually evolving environment; Accelerating Change in Medical Education (ACE) by continuing the collaboration with medical schools to create a system that trains physicians to meet the needs of today's patients and to anticipate future changes, and launching a new initiative to transform residency in a similar fashion; and Improving Health Outcomes (IHO) by enabling physicians and health teams to partner with patients, communities and public and private-sector organizations to slow or reverse the increasing prevalence of hypertension and pre-diabetes.

AMA's critical work in Advocacy continues to be focused on efforts to reduce administrative burden for physicians, such as the Centers for Medicare & Medicaid Services (CMS) adopting AMA recommendations regarding coding changes and relative work values for outpatient evaluation and management (E/M) services.

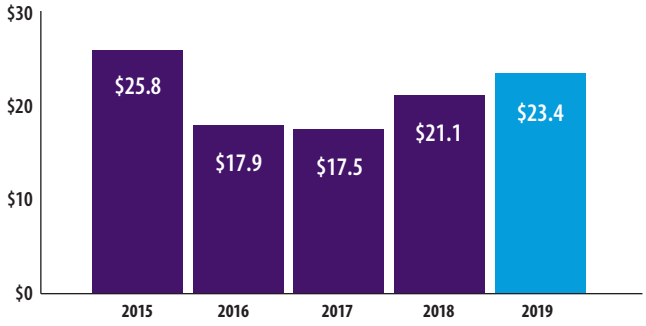
AMA's business formation and commercialization enterprise in Silicon Valley, Health2047, Inc. (Health2047), has made substantial progress on key projects, including the spinoffs of two new companies in 2019. Health2047 will continue to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice.

2019 saw many other important activities, including the successful beta launch of the AMA Ed Hub, providing trusted, high-quality education to physicians and other members of the health care team who seek to stay current and continuously improve the care they provide; the establishment of AMA's Center for Health Equity, with a goal of embedding health equity in all the work of the AMA; continued physician engagement efforts through enhanced digital marketing and content; and ongoing development of projects in the Integrated Health Model Initiative (IHMI) to enable interoperable technology solutions and care models, incorporating meaningful data elements around function, state and patient goals.

In 2019, AMA is reporting a $12.8 million net operating loss; which includes a $36.2 million noncash pension termination expense that was reclassified from non-operating results. Excluding the noncash pension termination expense, AMA is reporting $23.4 million in net operating income (pro forma), reflecting continued growth in revenue, offset by additional investment in the focus areas, core activities and new initiatives.

Pro forma net operating results

(in millions)



The AMA is committed to its responsibility to ensure that the organization focuses its finite resources on its core activities and strategic arcs while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' presence and voice are central to the overall success of our AMA.

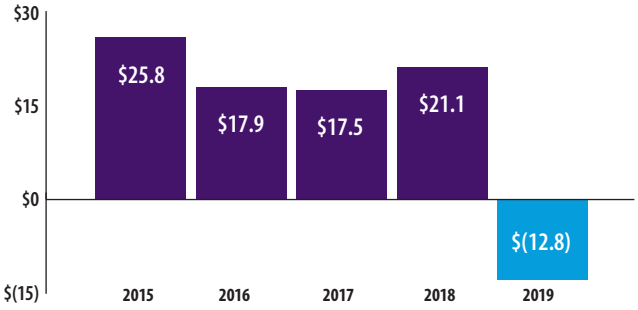
The following pages discuss the 2019 consolidated results from operations, financial position and cash flows, as compared to 2018. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



In 2019, the AMA finalized termination of its defined benefit pension plan, providing lump sum payments to individuals that elected that option and purchasing a group annuity plan for participants that chose to remain in the plan. AMA recorded a $38.2 million noncash reclassification of prior actuarial losses from non-operating expense to operating expense, titled pension termination expense, as well as reclassifying a $2 million noncash tax benefit to income tax expense that had been previously reported as a non-operating credit. The pension plan liability previously recorded on AMA's financial statements as part of regular pension expense was eliminated by paying a $7 million contribution to the pension plan.

Excluding the $36.2 million noncash pension termination expense (net of the $2 million tax credit), AMA would report $23.4 million in net operating income.

In addition, AMA adopted a new accounting standard related to defined benefit retirement plans that impacted how AMA accounted for the postretirement health care plan. AMA did not adopt the new standard for the pension, as the pension plan was terminated. The new standard requires that components of the actuarially calculated expense that do not relate to service, such as interest cost and amortization of actuarial gains and losses, be reported as non-operating expense. The standard was adopted in 2019, and 2018 results were restated, as required, to retroactively reflect the change.

Results discussed below reflect AMA's actual results from operations, including the one-time noncash pension termination expense. Any discussion of results excluding the one-time pension termination expense will be described as pro forma results.

In addition, all five-year charts shown in this report have been restated to exclude the postretirement health care costs reported as non-operating expense in 2018 and 2019, due to adopting the new accounting standard. This will provide comparability across all five years.

Revenues

In 2019, total revenues improved by $31 million over the prior year, with continued growth in AMA's royalties, journal site licensing and journal open access fees, as well as an increase in investment income. Coding book sales and journal print advertising declined during 2019, reflecting the ongoing transition from print to digital.

The number of AMA dues paying memberships increased in 2019 by 3 percent, achieving nine years of consecutive growth in membership. Similar to results in previous years, increases occurred in lower dues paying categories such as group memberships and sponsored memberships, which resulted in a small dues revenue decline of just under 4 percent.

Consolidated investment income, which is dividend and interest income, net of management fees, increased $2.2 million in 2019, reflecting larger investable balances and an increase in interest rates in the first part of 2019, although rates returned to historic low levels by the end of the year. Market gains or losses are not included in investment income and are reported as non-operating results.

Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2019, cost of products sold and selling expenses were largely unchanged from the prior year.

Contribution to general and administrative expenses

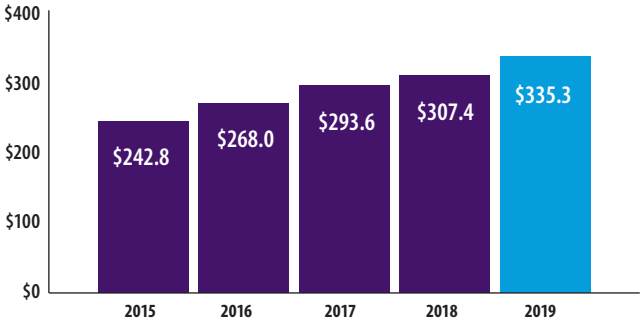
Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $30.9 million to $364.5 million in 2019, with

Books and Digital Content accounting for most of the change. Revenue improvements from royalties, offset by the declining book sales discussed above, were the key factors.

Pro forma general and administrative expenses

(in millions)



Pro forma general and administrative expenses, excluding the pension termination expense, rose $27.9 million in 2019, or just over 9 percent, but less than the budgeted increase for 2019 of 18 percent.

Compensation and benefits increased $16 million, or approximately 8 percent with costs increasing for both compensation and benefits. Compensation, including temporary help, was $12.2 million higher in 2019, a 9.8 percent increase, with almost half due to staff additions and the other half resulting from salary or merit increases. Staff additions occurred primarily in the strategic focus areas and revenue generating groups. Associated fringe benefit costs increased $2.1 million in total, mainly for payroll taxes and medical costs. Higher incentive compensation accounted for $2.9 million of the increase in compensation and benefits as the salary base increased and key performance indicators were achieved in 2019.

Occupancy costs increased $2.1 million in 2019, largely due to higher operating costs and property taxes associated with the office leases in Chicago and Washington, D.C., as well as additional office space for Health2047.

Technology costs increased $2.5 million in 2019, resulting from higher licensing and maintenance costs as well as expanded use of hosted solutions in lieu of building custom inhouse applications, the latter reducing costs of future ongoing support.

Marketing and promotion costs rose $2.8 million in 2019, due to a variety of activities. AMA launched a major expansion of its digital content and marketing program in 2018 to enhance AMA's reputation, visibility and effectiveness among physicians, healthcare influencers and the public. Expansion of this program in 2019 caused a $1.2 million increase in marketing and promotion.

Membership marketing costs increased $0.6 million in 2019. The IHO awareness campaign on new blood pressure measures and digital advertising for IHO's blood pressure modules such as Achieving Accuracy: BP measurement resulted in a $0.9 million increase in costs.

Outside professional services declined in 2019, mainly due to completion of projects in membership marketing for engagement and retention of students and residents; in IHO for new and enhanced MAP tools and resources; and in PS2 for creating practice transformation and payment models.

A $3.2 million increase in other operating expenses was driven by a $1.1 million increase in grants for the new "Reimagining Residency" initiative, a $0.8 million grant to an affiliate and a $1.6 million increase in Health2047 costs, mainly due to an increased reserve for bad debts.

Operating results before income taxes

The AMA reported a $9 million pre-tax operating loss in 2019. Excluding the $38.2 million noncash pension termination expense (pre-tax), the 2019 pro forma pre-tax results were $29.2 million, compared to $26.2 million in 2018. The $31 million increase in revenue was almost entirely offset by the general and administrative expense increases described above, as planned in AMA's 2019 budget.

Income taxes

Taxes decreased $1.3 million in 2019, which includes a $2 million noncash tax benefit related to the pension plan termination.

Net operating results

The reported net operating loss, including the noncash pension termination expense, was $12.8 million. On a pro forma basis, AMA's operating income totaled $23.4 million in 2019, up $2.3 million from the prior year, driven mainly by improved revenues exceeding expense increases.

Non-operating items

The AMA reported a $75 million gain in the fair value of its portfolio during 2019 after a $39.7 million loss in 2018.

As a result of adopting the new accounting standard for postretirement benefit plans, non-operating results also include $3.9 million and $3.1 million in postretirement plan interest expense and recognized actuarial gains and losses for 2019 and 2018, respectively. The 2018 results were restated to reflect the reclassification of $3.1 million from compensation and benefits in operating results to non-operating items.

Revenue in excess of (less than) expenses

Revenues exceeded expenses by $58.5 million in 2019, a combination of the $12.8 million operating loss, the $75 million gain in fair value in the portfolio and $3.7 million in other non-operating expenses. Expenses exceeded revenues by $21.7 million in 2018, mainly due to the fair value losses in the investment portfolio.

Change in total association equity

Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2019, the net credit to equity related to defined benefit postretirement plans totaled $17 million. This included a noncash credit of $36.2 million due to reclassifying prior actuarial losses and prior service cost for the pension plan (net of tax) to operating expense, upon finalizing the pension plan termination.

Excluding the $36.2 million credit from reclassifying the pension plan expense to operating expense, the AMA reported a $19.2 million charge to equity for the postretirement health care plan. Actuarial losses due to year-end lower interest rates that increased the present value of plan liabilities accounted for $18.2 million of the charge.

In 2018, the net credit to equity related to defined benefit postretirement plans totaled $10.8 million. Actuarial gains in both the pension plan and the postretirement health care plan, resulting from year-end higher interest rates that decreased the present value of plan liabilities, totaled $22.2 million. In addition, claims experience in the retiree health plan was lower than the actuarial expectation, resulting in a $3.8 million actuarial gain. Recognition of actuarial losses and prior service credits in the postretirement health care plan, as well as other minor variations from actuarial expectations and prior service costs, added $3.5 million to the gains. Plan assumptions were updated in 2018 to reflect the pension plan termination which resulted in a $10.7 million actuarial loss. Portfolio returns in the pension plan were less than the actuarial expectation, resulting in an additional $7.2 million loss. Deferred tax expense of $0.8 million reduced the overall gain slightly.

The AMA reported a $75.4 million increase in association equity in 2019. This reflects the amount by which revenues exceeded expenses, plus the credits to equity for changes in defined benefit postretirement plans discussed above and a small decrease in donor-restricted equity.

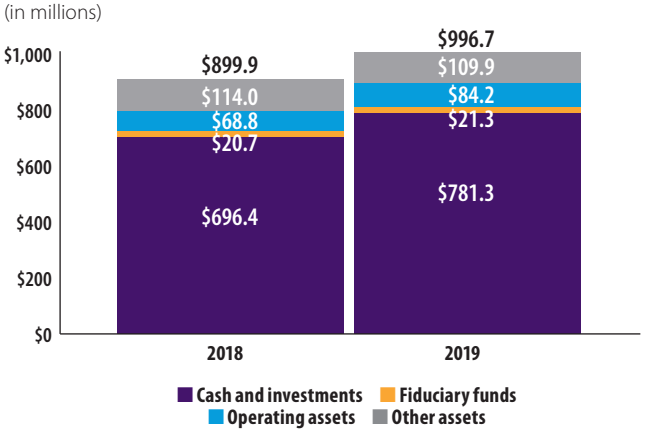
The AMA reported a $10.9 million decrease in association equity in 2018, combining $21.7 million of expenses in excess of revenues with $10.8 million in credits to equity for changes in defined benefit postretirement plans. There was no change in donor-restricted equity in 2018.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets

(in millions)



The AMA's total assets increased $96.8 million in 2019. This includes an $84.9 million increase in cash and investments resulting from $12.1 million in free cash flow, a $75 million gain in the fair value of investment securities, reduced by $2.2 million of investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $15.4 million in 2019, primarily due to an $11 million increase in accounts receivable from higher fourth quarter royalty revenue. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets includes operating lease right-of-use assets, property and equipment and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets decreased due to amortization of the asset that represents the present value of lease payments. Property and equipment net book value decreased $1.7 million, as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities increased $18.1 million in 2019, mainly due to the increase in postretirement health care plan liabilities included as accrued payroll and employee benefits, resulting from lower interest rates at year end increasing the present value of the liabilities.

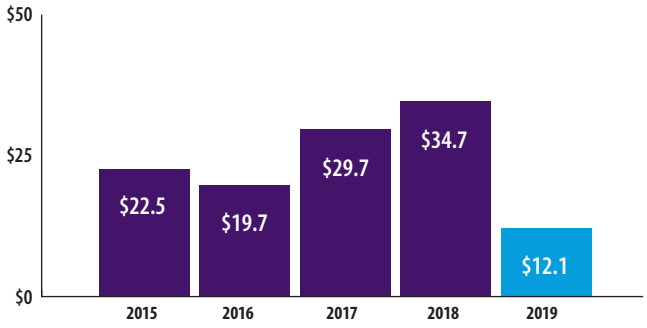
Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

Cash flows

Cash, cash equivalents and donor-restricted cash declined $10.4 million and $6.7 million in 2019 and 2018, respectively. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash

(in millions)



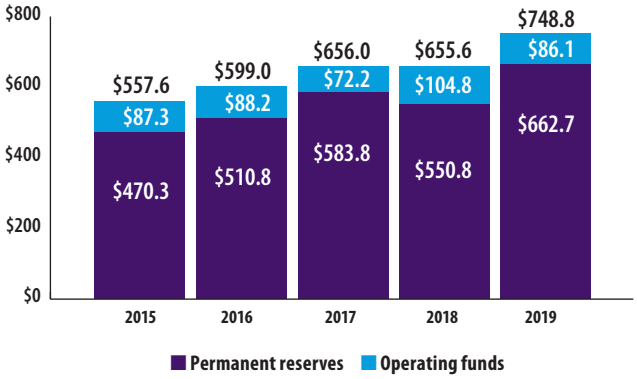
Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash in 2019 totaled $12.1 million, $22.6 million less than the 2018 results, with a $24.9 million decline in cash from operations partially offset by lower capital spending. The decline in cash from operations was due to substantially higher year end accounts receivable and making a final pension contribution of $7 million in 2019.

Reserve portfolios

Reserves

(in millions)



The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries, and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2019, the reserve portfolio's value was $662.7 million compared to $550.8 million in 2018, a $111.9 million increase. That increase was the result of a $75.1 million gain in the fair value of the reserve portfolios plus a $36.8 million transfer of 2018 excess operating funds to reserves. Operating funds totaled $86.1 million in 2019, down $18.7 million from 2018.

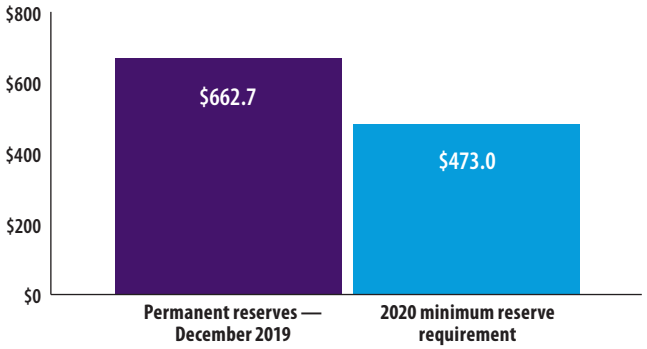
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term pension, postretirement and lease liabilities (net of the right of use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligations for pension and postretirement health care, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)



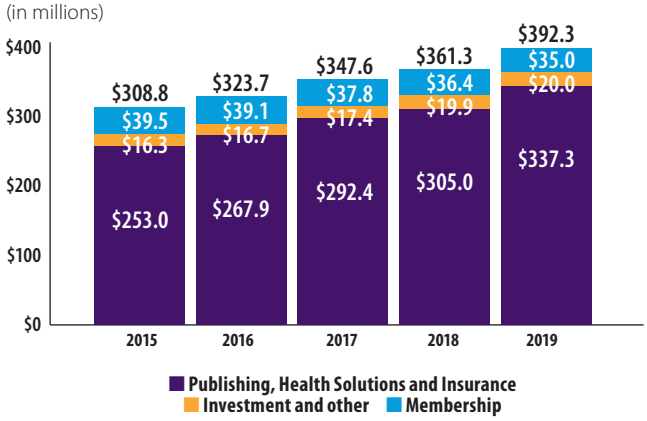
Group operating results

The AMA is organized into various operating groups: Membership, Publishing, Health Solutions & Insurance, Strategic Focus Areas, Core Operations, Administration and Operations, Affiliated Organizations, Unallocated Overhead and Health2047 (including subsidiaries). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. Prior year financial results have been restated to be consistent with the current year reported results for each group.

Revenues

Total revenue

(in millions)



Membership

The Membership group's total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues include the gross dues revenue collected, reduced by commissions paid to state societies, and equal the membership dues revenue reported on the statement of activities.

The AMA achieved its ninth consecutive year of increases in the number of dues-paying members, although total dues revenue declined in 2019. The number of dues paying members increased 3 percent in 2019, and total membership increased 2.4 percent in 2019, as compared to 2.8 percent in 2018.

Gross dues revenue was $35.1 million, a $1.4 million decrease from 2018, as membership increased in categories with lower average dues rates, such as group practices, retirees, residents and sponsored memberships. Interest expense on lifetime memberships was $0.1 million in both 2019 and 2018.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's active subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' income was $14.5 million in 2019, a $2.1 million increase over the prior year, due to an increase in the investable fund balances as well as an improvement in interest rates in the early part of 2019. Continued low interest rates have resulted in reduced levels of income in the portfolio during the last several years.

The net gain or loss on investments is not included in operating results, but reported as a non-operating item. This amount is in addition to the investment income discussed above, and totals a gain of $75 million in 2019, compared to a $39.7 million loss in 2018. The total investment gain, including investment income, on the reserve portfolios was 15.6 percent. That compares to a composite benchmark index of 17.1 percent.

Publishing, Health Solutions and Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In 2018, *JAMA* launched its third new journal—JAMA Network Open, a fully open access journal. This follows the successful launches of *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased $2.4 million in 2019, as the print advertising market slowed in 2019. This was partially offset by growth in site licensing and open access fees.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased $3.4 million in 2019 due to increased royalties, largely from new customers.

AMA-published books and coding products, such as CPT books, workshops and licensed data files, make up the Books and Digital Content unit. Revenues in this unit increased by $29.5 million. Royalties and digital content sales drove this increase, as the market for electronic use of digital coding products continues to expand. A change in the pricing models for 2019 was also a factor. Coding book sales declined again in 2019 as the move from print products to digital data continues to adversely impact print product sales.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Insurance Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis. The Insurance Agency revenues were up $1.8 million in 2019, mainly due to an increase in commission rates from a new underwriter. The Insurance Agency, as broker, receives a commission on insurance policies sold.

Other revenues

Other revenues are derived from grants and fee income. These increased $0.5 million in 2019, largely due to higher grant and fee income in the core activities. Health2047 revenues are discussed separately at the end of this discussion and analysis.

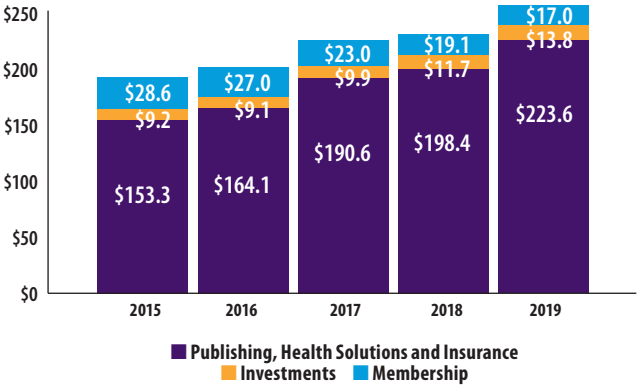
Contribution margin (net expenses)

Contribution margin equals unit revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the unit, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership, Publishing, Health Solutions & Insurance, as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

Membership's contribution margin decreased $2.1 million in 2019 due to the combination of a dues revenue decline, increased marketing efforts focused on member retention and costs for digital marketing programs for membership.

Investments (AMA-only)

The $2.1 million increase in contribution margin was attributable to the investment revenue improvement.

Publishing, Health Solutions and Insurance

Publishing, Health Solutions and Insurance results were up $25.2 million in 2019. Increased royalty and digital product revenue, site licensing, insurance commissions and open access fees were the major drivers.

Contribution margin declined $4.4 million in Publishing, from the $2.4 million revenue drop coupled with $2 million in higher costs for the new open access journal and expansion of operations.

Database Products reported a $1 million margin improvement as the improved royalty revenue was largely offset by increased costs associated with moving to a new technology platform.

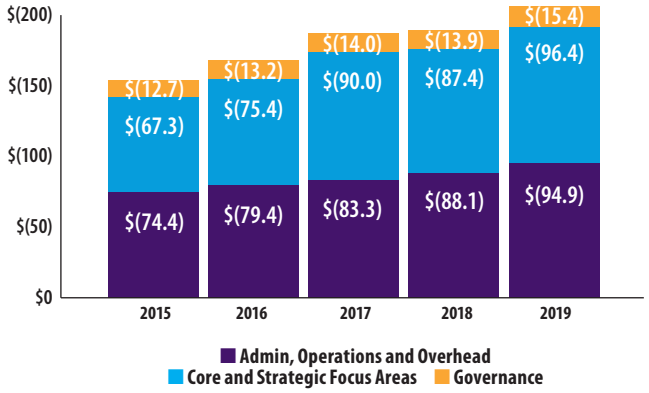
Books and Digital Content contribution margin rose $27.3 million, largely on the strength of continued growth in royalties and digital product revenues, somewhat offset by costs to expand services and international distribution capability.

The Insurance Agency/Affinity Products margin increased $2 million in 2019, with small cost decreases adding to the revenue improvement.

Other business operations net expenses were up $0.7 million, due to expanding compliance efforts.

Net expenses

(in millions)



Strategic focus areas and core operations

The Strategic Focus Areas include direct costs associated with the units for IHO, ACE, PS2 and IHMI.

IHO involves AMA focusing on two of the nation's most prevalent issues: Cardiovascular disease and type-2 diabetes, and setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions. To help prevent type-2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at risk patients to in-person or online diabetes prevention programs (DPP's).

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help manage their patients' high blood pressure (BP). These resources are available to all physicians and health systems as part of Target: BP™, a national initiative co-led by the AMA and the American Heart Association. In 2019, AMA opened a new office in South Carolina with nationally recognized experts to assist in scaling the Target BP MAP Program across the country to major health care organizations.

Through ACE, in 2013 the AMA launched a multi-year grant program aimed at bringing innovative changes to medical education. The consortium of schools has been substantially expanded and now acts as a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country. ACE launched its "Reimagining Residency" initiative in 2019 at 11 partner institutions in order to continue creating and disseminating innovations to better train physicians to meet the needs of patients today and in the future.

One of the key outcomes of the ACE consortium was the development of "Health Systems Science," the first textbook that focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. The second edition will be published in 2020.

PS2 includes three major streams of work: practice transformation, digital health, and payment and quality, all designed to improve the day to day practice and professional experience of physicians and remove obstacles to care.

The goals of this initiative are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other resources focused on helping physicians implement practice improvements, improving the usability of electronic health records, and shaping the evolution of payment models for sustainability and satisfaction. In 2019, large scale pilots were launched, with state medical societies, to identify best practices.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) FHIR (Fast Healthcare Interoperability Resources), the Gravity Project and others. HL7 is an international community of healthcare subject matter experts and information scientists who work together to create accredited standards for the exchange, management and integration of electronic healthcare information. IHMI also collaborates on projects with other organizations across the health care industry to make health data more useful and actionable. IHMI collaborates with all groups across AMA around innovation.

The Strategic Focus Areas continued to expand staff and operations during 2019, as planned in the 2019 budget. Most of the $5.5 million net expense increase in 2019 was due to the expansion of IHO's work in hypertension and the awarding of new grants for the "Reimagining Residency" initiative.

Core Operations includes five groups: Advocacy; Health & Science, Health Equity and Core Medical Education; AMA Ed Hub, Enterprise Communications & Marketing and Member Experience (MMX), previously called Physician Engagement.

The Advocacy Group includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. Significant results in 2019 included averting material cuts in office visit payments proposed by CMS in the E/M code collapse as CMS adopted AMA recommendations from the RUC and CPT; creating a roadmap to use nationally on issues such as Medication Assisted Treatment, based on AMA and Manatt Health in-depth research on the opioid epidemic in four states; and successfully lobbying for federal funding of long-sought gun violence research at CDC and NIH. In 2019, Advocacy net spending totaled $26.8 million, up $0.5 million from the prior year.

Health & Science, Health Equity and Core Medical Education includes Science; Core Medical Education; Ethics; and Grants, as well as the newly created Center for Health Equity. The group is involved in developing AMA policies on scientific issues for the House of Delegates (HOD); public health advocacy; defining or influencing standards for undergraduate, graduate and continuing medical education; establishing and disseminating ethical standards for the profession; enhancing quality of care and patient safety; and providing support for the Councils on Ethical and Judicial Affairs, Science and Public Health and Medical Education.

The Center for Health Equity will help drive health equity initiatives throughout the AMA by working effectively across a matrixed organization, establishing a system/structure to embed and track equity. The initial work has been focused on embedding equity across the organization. Initial partial year costs for Health Equity were more than offset by a planned decrease in AMA grant support for PCPI and increased revenue for the U.S. Adopted Names program driving a $0.4 million decrease in net expenses for the overall group.

A major initiative for AMA in the last several years has been creating and expanding education delivery services through the AMA Ed Hub, formally launched in late 2018, providing a digital platform for lifelong professional development. The expansion of the AMA Ed Hub to create a central distribution channel for mission impact and physician engagement caused a $1.6 million net expense increase in 2019.

Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative, proactively communicating the "One AMA" culture to demonstrate how the AMA is creating societal value while driving the future of medicine. Net expenses declined by $0.7 million in 2019, largely due to the conclusion of a project to identify major influencers in health care.

MMX packages AMA's initiatives into digital content and platforms that expand AMA's reach, engagement with physicians and help acquire or retain individual and new group members. The goals are increased uptake by physicians of AMA's offerings (mission activities, membership, educational offerings, etc.), sharper market insight to enable successful new programs, and expanded opportunities for physicians to participate in the mission and membership of the AMA. In 2019, there was a $2.5 million increase in net spending largely related to expansion of the digital content, publishing and marketing activities within AMA.

Governance

Governance includes the Board of Trustees, the HOD, Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Focus Areas and Core Operations. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2019, Governance net spending was up $1.5 million, mainly in the HOD and Sections as a result of expanding section staff support and increased travel and meeting costs.

Administration and operations

These units provide administrative and operational support for Publishing and Health Solutions, Membership and all other operating groups. Net expenses were up $3.1 million in 2019, or 4.7 percent. Staff expansion and increased use of consultants in Information Technology accounted for almost half the increase. Finance and Human Resources areas also reported higher costs for staff expansion. The remaining units reported little or no change in costs.

Affiliated organizations

Affiliated organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. Net expenses increased $0.8 million in 2019 due to a one-time grant to an affiliated entity.

Unallocated overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2019, these expenses totaled $24.4 million, up from $21.5 million in 2018. Higher incentive compensation accounted for the entire increase.

Health2047 and subsidiaries

AMA has established a business formation and commercialization enterprise, designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The Board approved the use of reserves to establish this subsidiary with plans to use third party resources to assist in funding spinoffs with commercial potential in future years.

Health2047 funds initial projects and moves those that demonstrate commercial appeal into separate companies, along with necessary seed funding for the new companies. After the initial stage, it is expected that these companies should command additional investment from third parties to begin commercialization of the product, either through debt or equity financing. At some point in the future, the spinoffs will be sold or liquidated, at which time, AMA would expect to receive a financial return.

Since 2017, Health2047 has spun off four companies, Akiri, Inc. (Akiri), First Mile Care, Inc. (FMC), HXSquare, Inc. (HXS) and Zing Health Holdings, Inc. (Zing). Akiri and FMC are subsidiaries of Health2047 while HXS and Zing are not wholly owned or controlled by Health2047 and therefore not consolidated. Health2047 operating costs, as well as two of the four spinoffs, Akiri and FMC, are included in the consolidated financial results reported herein. Health2047's proportionate share of net earnings or loss from the two affiliated companies is reported as one line on AMA's financial statements and included in Health2047's operating results. Third-party financing is expected to cover most costs for the two entities not consolidated with Health2047, HXS and Zing.

Akiri is a network for facilitating the flow of health care data as well as a protocol for transferring the data in real time, acting as a network for securely transmitting information through a standardized system of codes by leveraging blockchain principles.

FMC is building an affordable, scalable, and sustainable platform that helps people combat prediabetes. Based on the proven DPP method being developed by the CDC, FMC's program fosters community-based, connections that provide people with the guidance they need in the settings where they make their lifestyle choices.

Health2047 has investment income and provides administrative services to a venture fund associated with Health2047, netting $0.3 million and $0.6 million revenue in 2019 and 2018, respectively. Health2047 also reflects its proportionate loss in earnings of affiliates, totaling $2.2 million in 2019 as revenue.

Expenses increased in 2019 by $2.4 million, mainly due to an increase in reserve for bad debts. The lower service revenue, losses from affiliates and increase in expenses resulted in a $4.9 million increase in net expenses in 2019, reflects the results of all Health2047 companies.

The summary of group operating results is included on the following page.

American Medical Association group operating results

	Revenues		Margin (expenses)	
(in millions)	**2019**	**2018**	**2019**	**2018**
Membership	**$ 35.0**	$ 36.4	**$ 17.0**	$ 19.1
Publishing, Health Solutions & Insurance				
Publishing	**60.2**	62.6	**4.8**	9.2
Database Products	**59.4**	56.0	**45.9**	44.9
Books and Digital Content	**176.8**	147.3	**152.2**	124.9
Insurance Agency/Affinity Products	**40.9**	39.1	**23.5**	21.5
Other business operations	**-**	-	**(2.8)**	(2.1)
	337.3	305.0	**223.6**	198.4
Investments (AMA-only)	**14.5**	12.4	**13.8**	11.7
Strategic Focus Areas & Core Operations				
Strategic Focus Areas	**1.0**	0.3	**(36.3)**	(30.8)
Advocacy	**0.7**	0.8	**(26.8)**	(26.3)
Health & Science, Health Equity & Core Medical Education	**4.3**	4.2	**(6.9)**	(7.3)
AMA Ed Hub	**0.3**	0.3	**(7.5)**	(5.9)
Enterprise Communications	**-**	-	**(3.7)**	(4.4)
Marketing and Member Experience	**-**	-	**(15.2)**	(12.7)
	6.3	5.6	**(96.4)**	(87.4)
Governance				
Board of Trustees and Officer Services	**-**	-	**(6.3)**	(5.9)
House of Delegates, Sections, Special Constituencies & International	**0.1**	0.1	**(9.1)**	(8.0)
	0.1	0.1	**(15.4)**	(13.9)
Administration and operations				
Information Technology	**-**	-	**(31.0)**	(29.6)
Corporate Services	**-**	-	**(5.5)**	(5.4)
Senior Executive Management	**-**	-	**(5.9)**	(6.0)
General Counsel	**-**	-	**(6.4)**	(6.5)
Customer Service & Other	**-**	-	**(3.3)**	(3.4)
Finance & Risk Management	**-**	-	**(7.3)**	(6.7)
Human Resources	**-**	-	**(6.3)**	(5.4)
Strategic Planning and Health Analytics	**-**	-	**(3.9)**	(3.5)
	-	-	**(69.6)**	(66.5)
Affiliated Organizations	**0.1**	0.1	**(0.9)**	(0.1)
Unallocated Overhead	**0.9**	1.1	**(24.4)**	(21.5)
Health2047 & Subsidiaries	**(1.9)**	0.6	**(18.5)**	(13.6)
Consolidated revenue and income before tax and noncash pension termination expense	**$ 392.3**	$ 361.3	**29.2**	26.2
Income tax expense (excluding pension termination benefit)			**(5.8)**	(5.1)
Consolidated net operating income – pro forma			**23.4**	21.1
Noncash pension termination expense, net of tax			**(36.2)**	-
Consolidated net operating (loss) income			**$ (12.8)**	$ 21.1

2019 CONSOLIDATED FINANCIAL STATEMENTS

American Medical Association and subsidiaries

Consolidated statements of activities

Years ended December 31

(in millions)	2019	2018
Revenues		
Membership dues	$ 35.1	$ 36.4
Advertising	11.9	14.9
Journal print subscription revenues	4.2	4.7
Journal online revenues	28.7	28.5
Other publishing revenue	14.8	13.9
Books, newsletters and online product sales	27.4	30.5
Royalties and credentialing products	208.4	172.6
Insurance commissions	37.0	36.2
Investment income (Note 4)	15.5	13.3
Equity in losses of affiliates (Note 2)	(2.2)	-
Grants and other income	11.5	10.3
Total revenues	**392.3**	**361.3**
Expenses		
Cost of products sold and selling expenses	27.8	27.7
Contribution to general and administrative expenses	**364.5**	**333.6**
General and administrative expenses		
Compensation and benefits	204.5	188.5
Occupancy	21.8	19.7
Travel and meetings	18.0	15.3
Technology costs	26.7	24.2
Marketing and promotion	16.2	13.4
Professional services and consulting	24.0	25.4
Other operating expenses	24.1	20.9
Pension termination expense (Note 7)	38.2	-
Total general and administrative expenses	**373.5**	**307.4**
Operating results before income taxes	(9.0)	26.2
Income taxes (Note 9)	3.8	5.1
Net operating results	**(12.8)**	**21.1**
Non-operating items		
Net gain (loss) on investments (Note 4)	75.0	(39.7)
Defined benefit postretirement plan non-service periodic expense (Note 8)	(3.9)	(3.1)
Other	0.2	-
Total non-operating items	**71.3**	**(42.8)**
Revenues in excess of (less than) expenses	**58.5**	**(21.7)**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 7, 8 and 9)	17.0	10.8
Change in association equity	**75.5**	**(10.9)**
Change in donor restricted association equity		
Restricted contributions	0.3	0.3
Net assets released from restriction	(0.4)	(0.3)
Change in association equity – donor restricted	**(0.1)**	**-**
Change in total association equity	**75.4**	**(10.9)**
Total association equity at beginning of year	548.8	559.7
Total association equity at end of year	**$ 624.2**	**$ 548.8**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2019	2018
Assets		
Cash, cash equivalents and donor-restricted cash	$ 30.9	$ 41.3
Fiduciary funds (Note 2)	21.3	20.7
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.3 in 2019 and $0.2 in 2018	67.7	56.7
Inventories	2.7	2.2
Prepaid expenses and deposits	8.9	6.2
Deferred income taxes (Note 9)	4.9	3.7
Investments (Note 4)	750.4	655.1
Property and equipment, net (Note 6)	44.5	46.2
Operating lease right-of-use assets (Note 10)	56.6	60.7
Other assets (Note 5)	8.8	7.1
	$ 996.7	**$ 899.9**
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 16.6	$ 15.6
Accrued payroll and employee benefits (Notes 7 and 8)	157.1	134.1
Insurance premiums and other fiduciary funds payable	21.2	20.6
Income taxes payable (Note 9)	0.8	1.2
Operating lease liability (Note 10)	93.1	99.2
	288.8	270.7
Deferred revenue		
Membership dues	15.9	16.1
Subscriptions, licensing, insurance commissions and royalties	65.4	61.7
Grants and other	2.4	2.6
	83.7	80.4
Association equity	622.6	547.1
Donor-restricted association equity	1.6	1.7
Total association equity	624.2	548.8
	$ 996.7	**$ 899.9**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of cash flows

Years ended December 31

(in millions)	2019	2018
Cash flows from operating activities		
Change in total association equity	$ 75.4	$ (10.9)
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	12.3	12.1
Pension and postretirement health care expense	8.7	8.5
Noncash operating lease expense	10.1	9.5
Net (gain) loss on investments	(75.0)	39.7
Equity in losses of affiliates	2.2	-
Contribution to pension plan	(7.0)	-
Noncash charge (credit) for changes in defined benefit plans other than periodic expense (including pension termination expense) net of tax	19.2	(10.8)
Bad debt expense	2.3	0.2
Other	(0.2)	0.1
Changes in assets and liabilities		
Accounts receivable and other receivables	(13.3)	2.7
Fiduciary funds, net of payable	-	(0.5)
Inventories	(0.5)	0.1
Prepaid expenses and deposits	(2.7)	(0.3)
Deferred income taxes	-	(0.1)
Accounts payable, accrued liabilities and income taxes payable	(12.1)	(9.3)
Deferred rent obligations and tenant improvement allowances	-	0.6
Deferred revenue	3.3	6.0
Net cash provided by operating activities	22.7	47.6
Cash flows from investing activities		
Purchase of property and equipment	(10.6)	(12.9)
Investment in affiliates	(0.5)	-
Investment in convertible debt of affiliates	(1.7)	-
Purchase of investments	(486.9)	(412.6)
Proceeds from sale of investments	466.6	371.2
Net cash used in investing activities	(33.1)	(54.3)
Net change in cash, cash equivalents and donor restricted cash	(10.4)	(6.7)
Cash, cash equivalents and donor restricted cash at beginning of year	41.3	48.0
Cash, cash equivalents and donor restricted cash at end of year	**$ 30.9**	**$ 41.3**
Noncash investing activities		
Accounts payable for property and equipment additions	$ 0.5	$ 0.3

See accompanying notes to the consolidated financial statements.

Notes to financial statements

Years ended December 31, 2019 and 2018
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 256 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all association results as revenues and expenses in the consolidated statements of activities, except non-operating items. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted equity includes contributions for physician liability reform and scope of practice. These funds are restricted for use to areas such as national tort reform campaign efforts and are not available for general use within the AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries (collectively, the AMA). In 2015, AMA established a for-profit subsidiary, Health2047, Inc. (Health2047) designed to enhance AMA's ability to contribute to improvements in the U.S. health care system and population health. In 2017, Health2047 established a for-profit corporation, Akiri, Inc. (Akiri), designed to improve the securing, sharing and use of trusted health data. In 2018, Health2047 established a second for-profit corporation, First Mile Care, Inc. (FMC), that intends to create a platform, tools and support to combat pre-diabetes in the community. As of December 31, 2018, Health2047 has consolidated the operations of both Akiri and FMC. All intercompany transactions have been eliminated.

AMA, through its wholly owned subsidiary, Health2047, Inc. has investments in two affiliates: HXSquare, Inc., formed in January 2019, and Zing Health Holdings, Inc., formed in March 2019. The equity method of accounting is used to account for investments in affiliates in which the AMA has significant influence but not overall control. The investments were initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses (including unrealized and realized gains and losses) from the underlying entities from the dates of formation. The investment will be increased or reduced by any future additional contributions and distributions received, respectively.

At December 31, 2019, AMA ownership interest is 42.9 percent and 48 percent in HXSquare, Inc., and Zing Health Holdings, Inc., respectively. The book value of the equity method investments in affiliates, net of convertible debt issued by Zing Health Holdings, Inc., was approximately zero.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc. (Agency), in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.7 million and $2.6 million held at December 31, 2019 and 2018, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or market.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation is computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Nature of products and services

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

Timing of revenue recognition may differ from the timing of invoicing to customers. AMA records a receivable when revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or made available. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $66 million and $54.7 million as of December 31, 2019 and 2018, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes.

Reclassifications

In 2019, the AMA adopted Accounting Standards Update (ASU) No. 2017-07, *Compensation Retirement Benefits*, which changed the presentation within the consolidated statements of activities. As a result, the AMA conformed the 2018 amounts to the 2019 presentation. See Note 3 for additional information.

3. New accounting standards update

In March 2017, the Financial Accounting Standards Board (FASB) issued ASU No. 2017-07, *Compensation Retirement Benefits (Topic 715): Improving the Presentation of the Net Periodic Cost and Net Periodic Postretirement Benefit Cost*. This requires an employer to report the service cost component of retirement benefits in the same line item or items as the other compensation costs arising from services rendered by the pertinent employees during the period while the other components of net benefit costs will be presented in the consolidated statements of activities separately from the service cost component, as a non-operating expense.

The AMA adopted this guidance effective January 1, 2019, and classified the components of net periodic postretirement benefit cost other than service costs from compensation and benefits expense to non-operating expense within the consolidated statements of activities for all periods presented. Refer to Note 8 for additional information. The adoption of this guidance resulted in the reclassification of $3.1 million of net periodic benefit cost components other than service cost from compensation and benefits expense to non-operating expense for the year ended December 31, 2018 with no impact on change in total equity. Non-operating expense includes $3.9 million of benefit cost components other than service cost for the year ended December 31, 2019.

Due to the termination of the pension plan in 2018 and subsequent distributions from the plan in 2019, the AMA did not adopt the new accounting standard for costs related to the pension plan. See Note 7 for discussion on the pension plan termination.

In October 2018, the FASB issued ASU No. 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*. This aligns the accounting for costs to implement a cloud computing arrangement that is a service with the guidance on capitalizing costs for developing or obtaining internal-use software. The new standard is effective for the AMA for years beginning January 1, 2020. There will be no material impact on the AMA's consolidated financial statements upon adoption.

4. Investments

Investments include marketable securities and a private equity investment that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

Foreign and state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout opportunities in the United States and the European Union, as well as investments in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2019 totaled $26.4 million.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2019	2018
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 341.2	$ 271.0
Fixed-income mutual funds	15.4	15.7
	356.6	286.7
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	94.9	89.3
U.S. government and federal agency	247.4	238.5
Foreign government	25.9	25.9
U.S. state government	0.2	0.2
	368.4	353.9
Level 3 – Significant Unobservable inputs	-	-
Other investments measured at NAV – Private equity and venture capital funds	25.4	14.5
Investments	$ 750.4	$ 655.1

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2019	2018
Investment dividend and interest income	$ 18.1	$ 15.8
Management fees	(2.6)	(2.5)
	$ 15.5	$ 13.3

Non-operating items include:

	2019	2018
Realized gains on investments, net	$ 14.9	$ 15.2
Unrealized gains (losses) on investments, net	60.1	(54.9)
	$ 75.0	$ (39.7)

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $7.2 million and $5.9 million at 2019 and 2018, respectively.

Expenses related to the development of custom applications pursuant to a customer contract have been deferred until completion of development and recognition of the revenue under the contract. The deferred costs totaled $1.6 million and $1.2 million in 2019 and 2018, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

	2019	2018
Leasehold improvements	$ 38.4	$ 37.6
Furniture and office equipment	19.1	18.7
Information technology hardware and software	99.3	97.9
	156.8	154.2
Accumulated depreciation and amortization	(112.3)	(108.0)
	$ 44.5	$ 46.2

7. Retirement pension and savings plans

During 2019 and 2018, the AMA had a defined benefit pension plan covering eligible salaried and hourly employees. The plan was designed to pay a monthly retirement benefit that, together with social security benefits, provides retirement income based on employees' earnings, age, and years of service. Other employers participated in this plan and assets and liabilities were allocated between the AMA and other employers.

The AMA amended the pension plan to freeze pension benefits as of December 31, 2002. After that date, no individual could become a participant in the plan and no further benefits accrued under the plan. Individuals not vested as of that date were credited for future years of service for vesting purposes only. As a result, the projected benefit obligation equals the accumulated benefit obligation for this plan.

In June 2018, the AMA adopted plan amendments that terminated the pension plan effective October 31, 2018. Plan participants were given the option to accept either a lump-sum payment, immediate annuity or annuity contract purchased from an insurance company selected by AMA.

All pension distributions to participants and the purchase of a group annuity contract for participants electing to remain in the plan were finalized in 2019.

The changes in benefit obligation and plan assets were as follows:

	2019	2018
Change in benefit obligation		
Benefit obligation at beginning of year	$ 117.5	$ 124.0
Interest cost	4.2	4.0
Benefits paid	(6.0)	(10.9)
Termination benefit payments	(117.7)	-
Plan amendments	-	1.6
Actuarial loss (gain)	2.0	(1.2)
Benefit obligation at end of year	$ -	$ 117.5
Change in plan assets		
Fair value of plan assets at beginning of year	$ 113.5	$ 125.1
Return (loss) on plan assets	2.4	(0.7)
Employer contributions	7.0	-
Benefits paid	(6.0)	(10.9)
Termination benefit payments	(117.7)	-
Plan combination	0.8	-
Fair value of plan assets at end of year	$ -	$ 113.5

The funded status and amounts recognized in the AMA's consolidated statements of financial position at December 31 are:

	2019	2018
Fair value of plan assets	$ -	$ 113.5
Projected benefit obligation	-	117.5
Accrued pension costs	$ -	$ (4.0)

In accordance with ASC Topic 958-715, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, all previously unrecognized actuarial losses are reflected in the consolidated statements of financial position. The pension plan accumulated losses and prior service costs not yet recognized as a component of periodic pension expense but included in accumulated other comprehensive loss at December 31 are:

	2019	2018
Actuarial losses	$ -	$ 36.7
Prior service cost	-	1.6
	$ -	$ 38.3

The weighted-average assumptions used in determining the December 31 benefit obligations were:

	2019	2018
Discount rate	NA	4.1%

As discussed in Note 3, AMA did not adopt the new accounting standard for costs related to the pension plan due to the plan termination.

The AMA recognizes pension expense in its consolidated statements of activities. The provisions of ASC Topic 958-715 require the AMA to recognize settlement charges based on the lump-sum benefit payments in 2019 and 2018. The components of pension expense are:

	2019	2018
Interest cost	$ 4.2	$ 4.0
Expected return on plan assets	(4.9)	(6.5)
Lump-sum settlement charges	1.2	2.7
Recognition of prior service cost	0.2	-
Recognition of actuarial losses	2.4	3.6
Pension expense	$ 3.1	$ 3.8

Previously unrecognized actuarial losses and prior service cost recognized as a result of the pension termination are included on a separate line in the statements of activities titled pension termination expense:

	2019	2018
Actuarial losses	$ 37.6	$ -
Prior service cost	1.4	-
Plan combination	(0.8)	-
	$ 38.2	$ -

Pension-related changes, other than periodic pension expense, that have been included as a charge or credit to unrestricted equity consist of:

	2019	2018
Actuarial losses arising during period	$ (4.5)	$ (6.0)
Prior service costs for plan amendments	-	(1.6)
Reclassification adjustment for losses reflected in periodic pension expense	3.8	6.3
Actuarial losses reclassified to expense related to plan termination	37.6	-
Prior service cost reclassified to expense related to plan termination	1.4	-
Change in unrestricted equity	$ 38.3	$ (1.3)

Actuarial assumptions used in determining pension expense were:

	2019	2018
Discount rate	4.1%	3.4%
Expected long-term return on plan assets	4.8%	5.5%

Prior to the pension plan termination, to develop the expected long-term rate of return on plan assets assumption for the pension plan, the AMA considered the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns of each asset class. The expected return for each asset class was then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. The investment strategy reflected the expectation that equity securities will outperform debt securities over the long term. Assets were invested in a prudent manner to maintain the security of funds while maximizing returns within the plan's investment policy guidelines. The strategy was implemented utilizing actively managed assets from the categories listed below.

The investment goal was to provide a total return that, over the long term, increased the ratio of plan assets to liabilities subject to an acceptable level of risk. This was accomplished through diversification of assets in accordance with the investment policy. Periodic rebalancing occurred after the end of each calendar quarter, as was required by the policy.

During 2018 and early 2019, plan assets were liquidated and transferred to short-term investments in anticipation of distributing plan assets. All plan assets were distributed to participants or paid to the group annuity provider in 2019. The AMA has no additional obligation to the pension plan.

Equity securities include investments in large-cap, mid-cap, and small-cap companies primarily located in the United States and large- to mid-cap companies outside the United States through investments in mutual funds.

Mutual funds are open-ended SEC registered investment funds with a daily NAV.

Fixed income securities include primarily investment grade corporate bonds of companies from diversified industries and U.S. Treasury or Agency securities and foreign government securities, either through direct investment in bonds or through common trusts, as well as an allocation to high-yield U.S. corporate bonds, with a target of 4 percent of the portfolio.

The following fair value hierarchy tables present information about the AMA pension plan investments measured at fair value as of December 31.

	2019	2018
Level 1 – Quoted prices in active markets for identical securities		
U.S. equity securities	$ -	$ 31.6
International mutual funds	-	-
Fixed-income mutual funds	-	56.6
High-yield fixed income mutual fund	-	-
	-	88.2
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	-	8.9
U.S. government and agency	-	15.4
Foreign government	-	1.0
	-	25.3
Level 3 – Significant unobservable inputs	-	-
Marketable investments – all levels	$ -	$ 113.5

The AMA also has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, in its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $6.7 million and $6.1 million in 2019 and 2018, respectively.

During 2019 and 2018, the AMA also maintained a non-qualified, unfunded supplemental pension plan for certain long-term employees. Participation in the plan was closed in 1994. The AMA recognized the liability in its consolidated statements of financial position. The accumulated benefit obligation and liability totaled $0.3 million in 2018 and was eliminated in 2019 due to the final distributions resulting from the pension plan termination. The supplemental pension plan termination was triggered by the termination of the AMA defined benefit pension plan and all distributions were finalized in 2019.

The AMA uses the same discount rates noted above for the pension plan to determine the plan benefit obligation. There was a $0.1 million credit to expense for this plan and a $0.1 million increase in prior service costs due to plan amendments in 2018. Payments from the plan totaled $0.4 million in 2019 and $0.1 million in 2018.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with provisions similar to the AMA's pension plan and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and assets and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2019	2018
Benefit obligation at beginning of year	$ 92.3	$ 103.1
Service cost	1.6	1.7
Interest cost	4.2	3.5
Benefits paid	(4.1)	(4.0)
Participant contributions	1.2	1.2
Federal subsidy	0.1	0.2
Plan amendments	-	0.8
Actuarial loss (gain)	20.1	(14.2)
Accrued postretirement benefit costs	$ 115.4	$ 92.3

The postretirement health care plan accumulated losses and prior service credits not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

	2019	2018
Actuarial losses	$ 25.9	$ 6.3
Prior service credits	(1.0)	(1.8)
	$ 24.9	$ 4.5

An estimated $0.7 million in prior service credits and $1.6 million of actuarial losses will be included as components of non-operating expense in 2020.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2019	2018
Discount rate	3.3%	4.3%
Initial health care cost trend	5.84%	6.03%
Ultimate health care cost trend	4.5%	4.5%
Year that the rate reaches the ultimate trend rate	2038	2038

The AMA recognizes postretirement health care expense in its statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2019	2018
Service cost	$ 1.6	$ 1.7
Interest cost	4.2	3.5
Amortization of prior service cost	0.5	0.5
Amortization of actuarial gain	(0.8)	(0.9)
	$ 5.5	$ 4.8

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2019	2018
Actuarial (losses) gains arising during period	$ (20.1)	$ 14.2
Reclassification adjustment for recognition of actuarial losses	0.5	0.5
Reclassification adjustment for recognition of prior service credits	(0.8)	(0.9)
Plan amendments	-	(0.8)
Change in unrestricted equity	$ (20.4)	$ 13.0

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2019	2018
Discount rate	4.3%	3.7%
Initial health care cost trend	6.03%	6.22%

A one-percentage point change in assumed health care cost rates would have the following effect:

	1% increase	1% decrease
Effect on postretirement service and interest cost	$ 1.2	$ (0.9)
Effect on postretirement benefit obligation	$ 23.7	$ (18.5)

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2020	$ 3.0
2021	3.2
2022	3.4
2023	3.7
2024	3.8
2025 – 2029	23.0

9. Income taxes

The provision for income taxes includes:

	2019	2018
Operating		
Current	$ 6.2	$ 5.5
Deferred	(2.1)	(0.1)
Valuation allowance	(0.3)	(0.3)
	3.8	5.1
Tax expense related to credits or charges to equity		
Deferred	0.9	0.8
	$ 4.7	$ 5.9

In 2019, AMA made final distributions from the pension plan, as discussed in Note 7, resulting in a $2 million credit to income taxes reported in operating results and a $2.1 million income tax expense included as a charge to equity.

As prescribed under ASC Topic 740, *Income Taxes,* the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for both the pension and postretirement health care plans, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a

projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

	2019	2018
Benefit plans and compensation	$ 7.8	$ 6.6
Other	-	-
	7.8	6.6
Valuation allowance	(2.9)	(2.9)
	$ 4.9	$ 3.7

Cash payments for income taxes were $6.5 million and $5.9 million in 2019 and 2018, respectively.

10. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from five years to 15 years. Most leases have options to renew at then prevailing market rates. As any extension or renewal is at the sole discretion of AMA and at this date, is not certain, the renewal options are not included in the calculation of the ROU asset or lease liability. AMA also leases copiers and printers in several locations. All office and equipment leases are classified as operating leases.

Adoption of ASU No. 2016-02, *Leases*, as of January 1, 2018 resulted in AMA recording noncash transactions to establish the liability for the present value of future lease payments of $101 million and derecognition of liabilities for deferred rent and deferred tenant improvement allowances of $22.5 million and $17.1 million, respectively, increasing total liabilities by $61.4 million. An ROU asset in an equivalent amount of $61.4 million was also established on the consolidated statement of financial position.

During 2019, AMA entered into new office space operating leases which resulted in establishing an additional $1.2 million in ROU assets and $1.4 million liability for the present value of future lease payments.

The ROU assets will be amortized over the lives of the leases and the present value of the liability will be increased by interest cost and reduced by cash payments.

Operating lease costs totaled $10.1 million and $9.5 million in 2019 and 2018, respectively. Cash paid for amounts included in the measurement of lease liabilities totaled $12.3 million and $11.2 million in 2019 and 2018, respectively.

The weighted-average remaining lease term for operating leases is 9 years. The weighted-average discount rate used for operating leases is 5 percent .

The maturity of lease liabilities as of December 31, 2019:

2020	$ 12.7
2021	12.9
2022	13.0
2023	12.5
2024	12.2
2025 and beyond	53.4
Total lease payments	116.7
Less imputed interest	(23.6)
Present value of lease obligations	$ 93.1

11. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31, 2019 reduced by amounts not available for general use that

have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

Financial assets	$ 781.3
Less assets unavailable for general expenditures:	
Restricted by donor with purpose restrictions	(1.6)
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(662.7)
Financial assets available to meet cash needs for general expenditures within one year	$ 117.0

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

12. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

13. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2019, the AMA has evaluated all subsequent events through February 14, 2020, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition that have not already been recognized or that require disclosure.

14. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Strategic Focus areas and Core Operations, Publishing, Health Solutions and Insurance, Membership and other supporting services. Such allocations are determined by management on an equitable basis.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Focus Areas and Core Operations	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of goods sold and selling expense	$ -	$ 27.8	$ -	$ -	$ -	$ -	$ 27.8
Compensation and benefits	5.3	55.0	-	58.3	78.8	7.1	204.5
Occupancy	0.5	5.7	-	6.7	7.4	1.5	21.8
Travel and meetings	0.2	3.4	-	7.3	6.6	0.5	18.0
Technology costs	1.4	10.5	-	4.7	10.0	0.1	26.7
Marketing and promotion	9.5	0.9	-	5.1	-	0.7	16.2
Professional services and consulting	0.1	3.7	0.2	12.5	4.0	3.5	24.0
Other operating expense	1.0	6.7	0.5	8.1	4.6	3.2	24.1
Pension termination expense	-	-	-	-	38.2	-	38.2
2019 total expense	**$ 18.0**	**$ 113.7**	**$ 0.7**	**$ 102.7**	**$ 149.6**	**$ 16.6**	**$ 401.3**
Cost of goods sold and selling expense	$ -	$ 27.7	$ -	$ -	$ -	$ -	$ 27.7
Compensation and benefits	4.5	52.4	-	51.3	73.3	7.0	188.5
Occupancy	0.5	5.1	-	6.0	6.9	1.2	19.7
Travel and meetings	0.1	3.1	-	5.9	5.8	0.4	15.3
Technology costs	1.4	7.9	-	4.8	10.0	0.1	24.2
Marketing and promotion	8.9	0.6	-	3.3	-	0.6	13.4
Professional services and consulting	1.0	2.9	0.2	14.1	3.9	3.3	25.4
Other operating expense	0.9	6.9	0.5	7.6	3.4	1.6	20.9
2018 total expense	**$ 17.3**	**$ 106.6**	**$ 0.7**	**$ 93.0**	**$ 103.3**	**$ 14.2**	**$ 335.1**

Independent auditors' report

The Board of Trustees of American Medical Association

We have audited the accompanying consolidated financial statements of the American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2019 and 2018, and the related consolidated statements of activities and of cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the AMA's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the American Medical Association and subsidiaries as of December 31, 2019 and 2018, and the results of its activities and changes in its equity and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP
Chicago, Illinois
February 14, 2020

Written statement of certification of chief executive officer and chief financial officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2019 and 2018 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 14, 2020

2019–2020 OFFICERS AND TRUSTEES

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Note: Drs. Ehrenfeld, Kridel and Resneck serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Harris serves on all committees as an ex-officio member with vote.

EZI:19-410338:200:4/20

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2, June 2020

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. Both organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2019 Interim Meeting indicated that the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Society of Nuclear Cardiology and the Society of Cardiovascular Computed Tomography be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500 to implement.

APPENDIX
Exhibit A

GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:

   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Society of Nuclear Cardiology	683 of 2,805 (24%)
Society of Cardiovascular Computed Tomography	250 of 996 (25%)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3, June 2020

Subject: AMA 2021 Dues

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

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

RECOMMENDATION

2021 Membership Year

The Board of Trustees recommends expanding the number of years over which young physician dues rates increase to the full $420 rate. The new recommended rates increase over four years, from $60 to $420 versus the current two-year period, which better aligns with career and financial situations. All other dues rates remain unchanged. The Board of Trustees recommends that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Fourth Year of Practice	$ 315
Physicians in Their Third year of Practice	$ 210
Physicians in Their Second Year of Practice	$ 105
Physicians in Their First Year of Practice	$ 60
Physicians in Military Service	$ 280
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency Training	$ 45
Medical Students	$ 20

(Directive to Take Action)

Fiscal Note: The fiscal impact is expected to be net positive.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 4, June 2020

Subject:	Council on Legislation Sunset Review of 2008 and 2010 House Policies
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in Appendix 1 to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX 1 - RECOMMENDED ACTIONS ON 2008 & 2010 HOUSE POLICIES

Policy Number	Title	Text	Recommendation
D-120.957	Electronic Prescribing Incentive Program	Our AMA will continue to work with CMS to ensure that the Electronic Prescribing Incentive Program policies and reporting procedures provide the greatest flexibility to physicians who electronically prescribe and elect to participate in the program. Citation: Res. 223, I-08	Rescind – The Electronic Prescribing Incentive Program ended in 2013.
D-120.959	Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals	Our AMA urges the Centers for Medicare and Medicaid Services to immediately simplify the current Part D Prescription Drug Program Appeal Process by allowing physicians to submit an appeal without beneficiary approval. Citation: Res. 212, A-08	Retain – This policy remains relevant.
D-120.960	Internet Prescriptions	Our AMA will continue to advocate for its model federal legislation on Internet prescribing as the best means to effectively regulate the sale of prescription drugs, including controlled substances, over the Internet. Sub. Res. 506, A-08	Rescind – This policy has been accomplished. AMA evaluated federal Internet prescribing legislation and advocated AMA policy to members of Congress; H.R. 6353, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, was enacted in October 2008 and provides for strong penalties for the inappropriate provision of prescription medication on the Internet.
D-120.961	Personal Medication Supply in Times of Disaster	Our AMA urges the appropriate federal agencies to convene a meeting of medical societies, health care organizations, and other stakeholders to: (a) develop a national plan to ensure timely distribution of and access to medications for chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, which provides the essential health and medical information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency. Citation: BOT Rep. 15, A-08	Rescind – This policy has been accomplished. Relevant stakeholders were encouraged to: (1) develop a national plan regarding access to medications for chronic medical conditions in a disaster; (2) issue guidance on the appropriate stockpiling of medications for chronic conditions in a disaster; and (3) design a universal mechanism that provides essential health information.
D-130.991	Hospital Emergency Use	Our AMA Board of Trustees, to the fullest extent appropriate, will authorize continued support of federal legislation containing the same provisions as appear in H.R. 904, Access to Emergency Medical	Retain – This policy remains relevant but language should be added to provide additional

		Services Act of 1999, which would, among other things, ensure access to covered emergency medical services by group health plans and health insurance coverage without the need for any prior authorization determination and whether or not the physician furnishing such services is a participating physician. Citation: (Sub. Res. 706, I-00; Reaffirmed: BOT Rep. 6, A-10)	context on the purpose of the bill.
D-130.993	Confidentiality of Physician Peer Review "…"	(1) Our AMA will ~~study~~continue to assess the threat to the physician peer review process created by health care related federal regulation or statute, i.e. the Emergency Medical Treatment and Active Labor Act (EMTALA); and (2) If our AMA determines that Federal regulations or laws (including EMTALA) undermine state protections for the confidentiality of the peer review process, our AMA will take urgent action to establish protections for covering all Federal programs and related regulations for physician peer review. Citation: (Res. 219. I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain in part, with a modification: change "Our AMA will study the threat to the physician peer review process..." to read instead "Our AMA will continue to assess the threat to the physician peer review process…."
D-130.994	Limit Scope of EMTALA to Original Legislative Intent "…"	(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement. (2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare	Rescind – The report was submitted, and the general issues addressed in the directive are included in other policies/directives, such as The Future of Emergency and Trauma Care D-130.971; EMTALA -- Major Regulatory and Legislative Developments D-130.982; and Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950.

		conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose. (3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting. Citation: (Sub. Res. 217, I-00; Reaffirmed: BOT Rep. 6, A-10)	
D-160.988	Financial Impact of Immigration on American Health System	Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid. Citation: Res. 235, A-06; Reaffirmation I-10	Retain – This policy remains relevant.
D-165.943	Financial Assistance for Provision of Legally Mandated Health Care Services	Our AMA will request the continuation of funding for federally-mandated health care for non-residents. Citation: (Res. 229, A-10)	Retain – This policy remains relevant.
D-165.962	Health Savings Accounts for Older Americans	Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals. Citation: (Sub. Res. 702, A-04; Reaffirmation A-10)	Retain – This policy is still relevant.
D-165.971	Association Health Plans	Our AMA will work with federal legislators to ensure that any Association Health Plan program safeguard state and federal patient protection laws, including but not limited to those state regulations regarding fiscal soundness and prompt payment. Citation: (Sub. Res. 125, A-03; Reaffirmation A-10; Reaffirmed in lieu of Res. 105, A-10)	Retain – This policy is still relevant.
D-175.991	Action to Oppose The Office of Inspector General (OIG) "Draft Compliance Proposed Guidelines for Individual and Small Group Physician Practices"	Our AMA will: (1) condemn the OIG for its unwarranted punitive attitude and reject the final version of the "Office of the Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" and discourage its members from voluntarily participating in the program the until such time that a program is developed which is not burdensome to medical practices and focuses on education rather than criminal punishment; (2) aggressively utilize all available means to have CMS and the OIG appropriately define true fraud and true abuse in fair legal terms and desist in the criminalization of the practice of medicine and focus on education rather	Rescind – Our AMA is actively engaging with the OIG on fraud and abuse policy reform as evident in our recent letters on the Stark/AKS proposed rules.

		than criminal punishment; and (3) pursue such relief through legislative and regulatory advocacy. Citation: (Sub. Res. 204, I-00; Reaffirmed: BOT Rep. 6, A-10)	
D-175.994	Misapplication of Fraud and Abuse Laws	Our AMA: (1) will collaborate with state and component medical societies to develop an educational program for physicians on how to be in compliance with current fraud and abuse laws; and (2) continues implementation of our new web-based fraud and abuse tutorial system, and after careful review upon release of final Physician Office Compliance Guidelines issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services, provide member physicians with information and advice consistent with those guidelines, and to advocate for physicians with the OIG regarding these guidelines, and to advocate for physicians with the OIG regarding these guidelines. Citation: (Sub. Res. 244, A-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – Our AMA is actively engaging with the OIG on fraud and abuse policy reform and continues to provide updated information on our AMA's Medicare waste, fraud & abuse webpage.
D-185.998	Litigation Regarding Patient Care Guidelines	Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines. Citation: (BOT Rep. 4, I-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – Reference to the Batas case is no longer relevant and Policies H-373.995 (Government Interference in Patient Counseling) and H-410.980 (Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level) address the use of clinical guidelines.
D-190.975	Coordination of Benefits	Our AMA will work with payers and other appropriate parties to streamline the coordination of benefits attestation process by requiring employers to convey the attestation obtained during an open enrollment period to the payer and require the payer to accept the attestations from the employer as the only attestation required to release payment for dependent care. Citation: (Res. 721, A-10)	Retain – This policy remains relevant.
D-275.962	Threat to Medical Licensure	Our AMA will develop model legislation to ensure that medical licensure is independent of participation in any health insurance program. Citation: (Res. 717, A-10; Reaffirmation I-10)	Rescind – Model legislation has been developed. "An Act to Prohibit Mandatory Physician Participation in Health Insurance Programs as a Condition of Physician Licensure."
D-285.966	Benefit Management Companies Conflicts of Interest	Our AMA will study possible conflicts of interest and anti-competitive behavior when the owners of a benefit management company include providers or others who have a financial interest in the provision of medical services in the same market in which that benefit management company is contracted to help	Retain – this policy remains relevant.

		manage care, and where non-owner providers who are in competition with the owners of the benefit management company may be affected by the company's decisions. Citation: (Res. 825, I-10)	
D-315.980	Encryption Standards for Storage and Transmission of Patient Data	Our AMA will work with the US Department of Health and Human Services to develop and disseminate to its membership, current information on privacy and security risk assessment tools, including tools addressing encryption, to help ensure physicians can meet the requirements of "safe harbor" provisions contained in regulations promulgated pursuant to the HITECH Act. Citation: (Sub. Res. 828, I-10)	Rescind – The AMA maintains up-to-date information regarding HIPAA security and privacy as well as materials related to Meaningful Use (Promoting Interoperability).
D-385.981	Increased Administrative Fees for Multivalent Vaccines	Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population. Citation: (Res. 731, I-02; Reaffirmation I-10)	Rescind – The AMA has heard from a number of specialties and submitted comments to CMS about the crosswalk problems for immunization administration and has met with the Administration about this issue. In the 2020 MPFS, CMS left the door open so AMA will continue working with the Administration and urging them to fix this problem. AMA will also be commenting about this in our cover letter to the RUC recommendations, as well, so they will hopefully propose a change in the 2021 NPRM. AMA also has other policy on vaccines, including D-440.981.
D-390.959	Supervision Requirements for Outpatient Therapeutic Services	Our AMA will work with key stakeholders to make general supervision, rather than direct supervision, the requirement for Medicare payment for most, but not all, outpatient therapeutic services. Citation: (BOT action in response to referred for decision Res. 218, A-10)	Retain – the policy is still relevant.
D-390.960	Assuring Patients' Continued Access to Physician Services	1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010. 2. Our AMA is committed to a well funded and priority legislative and grassroots campaign to	Rescind – This directive has been implemented and superseded by more recent policy: D-390.957 (A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act); D-165.938 (Redefining AMA's Position on ACA

		ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's "Medicare Patient Empowerment Act" as the centerpiece legislation the AMA supports. 3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation. Citation: Sub. Res. 204, A-10; Appended: Res. 202, I-10	and Healthcare Reform); D-380.997 (Private Contracting by Medicare Patients); and H-383.991 (Right to Privately Contract). See also Board Report 11-A-11 (Effective AMA Action to Preserve Medicare Benefits for Patients)
D-390.966	Inappropriate Changes to Physician Medicare Participation Status by the Centers for Medicare & Medicaid Services	1. Our AMA will work with the Centers for Medicare and Medicaid Services, when necessary, to: a. return physicians to their self-designated Medicare non-participation status in those cases where CMS changed physicians from "non-participating" to "participating" status without the physicians? request or permission; b. have the agency provide written documentation of the erroneous change in the physicians? Medicare participation status thereby allowing those affected physicians to prove that they had no part in the appearance of fraudulent activity resulting from the erroneous CMS action; and c. have the agency provide written documentation of the erroneous change in the physicians' Medicare participation status thereby allowing those affected physicians to prove their innocence to their patients and to all of the Medigap providers whose erroneous explanation of medical benefits forms now imply wrongdoing by these non-participating physicians. 2. Our AMA will educate physicians, through appropriate means, of the option of electing the Medicare "non-participating status," together with simple instructions for effecting such a change of status. Citation: (Res. 105, A-07; Appended: Res. 227, I-10)	Retain – This directive remains relevant.
D-390.970	Recovery Audit Contractor Appeals	1. Our AMA will: (a) educate state medical societies and AMA-member physicians about the available methods for administrative and judicial appeals of Recovery Audit Contractors overpayment recoveries; (b) define common appeal scenarios and methods of appeals, provide technical support on appeals, and seek to consolidate cases for appeal with assistance of state medical societies via the AMA Litigation Center; and (c) continue to oppose the Recovery Audit Contractors' pilot projects and reaffirm existing policy D-390.972. 2. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with Recovery Audit Contractor audits	Rescind – The AMA has recently updated our RAC web information, including the appeals information. In addition, the RAC recoveries have steeply declined in recent years, a trend that seemed to coincide with Medicare's Targeted Probe and Educate Initiative.

		and prominently feature on our AMA website information about methods, resources, and technologies related to appeals of Recovery Audit Contractor overpayment recoveries as a members only benefit. Citation: Sub. Res. 603, I-06; Appended and Reaffirmed: Sub. Res. 603, I-10	
D-420.999	To Amend The Family Leave Act	Our AMA will work to simplify the Family Medical Leave Act form, reducing the physician work required for completion. Citation: (Sub. Res. 203, I-00; Modified: BOT Rep. 6, A-10)	Retain – this policy is still relevant.
D-450.980	Physician Time Spent with Patients and with Hospital Documentation	Our AMA will: (1) advocate for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures; (2) continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and (3) continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine. Citation: (BOT Action in response to referred for decision Res. 511, A-03; Reaffirmation I-10)	Retain – This policy is still relevant.
D-478.998	HIPAA Requirements for E-Commerce in Health Care	Our AMA will: (1) intensify its on-going effort to inform practicing physicians about the consequences of implementation (including financial implications) of the Health Insurance Portability and Accountability Act (HIPAA) regulations for transmission of electronic information; and (2) study strategies on implementation of the HIPAA regulations, such as a limit on the frequency of modifications, which will lessen the financial impact on physicians, with a report back to the AMA House of Delegates when final regulations are promulgated. Citation: (Res. 802, A-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – The AMA has worked on educational efforts around HIPAA and produced the required BOT Report (BOT Report 34-A-01, HIPAA Update; It was an informational report and was adopted).
D-478.999	Guidelines for Patient-Physician Electronic Mail	The BOT revisit "Guidelines for Patient-Physician Electronic Mail" when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented. Citation: (BOT Rep. 2, A-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind - Regulations around electronic transmission of PHI, including encryption, have been around for many years now and there is guidance from OCR on use of email from 2008. AMA

			also has policy H-478.997 (Guidelines for Patient-Physician Electronic Mail and Text Messaging), which was reaffirmed at I-18, providing guidelines to physicians for use of email and text.
D-510.992	Restoring Veteran Administration Physicians' Use of Prescription Drug Monitoring Programs	Our AMA will work to address the statutory restrictions which impede the ability of VA physicians and pharmacists in participating state-run Drug Monitoring Programs in order to better treat their veteran patients. Citation: (Res. 705, A-10)	Rescind - The VA Prescription Data Accountability Act, signed into law in 2017, requires Veterans Health Administration (VHA) health professionals with the authority to dispense controlled substances to provide data to their state PDMPs.
H-100.958	Inappropriate Pharmacy Advertising	Our AMA supports legislation or regulation that prohibits pharmacies and pharmacy benefit managers from using patient-specific drug information to directly market to patients. Citation: (Res. 215, I-10)	Retain – This policy remains relevant.
H-130.957	Emergency Transfer Responsibilities	Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to: (1) require that the Office of the Inspector General (IG) request and receive the review of the ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) prior to imposing sanctions; (2) make the ~~PRO~~QIO determination in alleged patient transfer violations binding upon the IG; (3) expand the scope of ~~PRO~~QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks; (4) restore the knowing standard of proof for physician violation; (5) recognize appropriate referral of patients from emergency departments to physician offices; (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer; (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient; (8) clarify the appropriate role of the on-call	Retain in part, with a modification to reflect the change from Peer Review Organization to Quality Improvement Organization (1) require that the Office of the Inspector General (IG) request and receive the review of the ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) prior to imposing sanctions; (2) make the ~~PRO~~ QIO determination in alleged patient transfer violations binding upon the IG (3) expand the scope of ~~PRO~~ QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks.

		specialist, including situations where the on-call specialist may be treating other patients; and (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act. Citation: (Sub. Res. 78, A-91; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	
H-130.959	Repeal of COBRA Anti-Physician Provisions	It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility. Citation: (Sub. Res. 145, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-165.834	National Pain Care	Our AMA will, in consultation with all interested Federation organizations whose members treat pain disorders, become actively engaged in the implementation and enabling process of the Patient Protection and Affordable Care Act (HR 3590) as it relates to pain care in SEC. 4305 et seq. pertaining to "Institute Of Medicine Conference On Pain," "Pain Research" and "Program For Education And Training In Pain Care." Citation: (Res. 226, A-10)	Rescind – This policy has been accomplished through the passage of the Affordable Care Act, and subsequent AMA advocacy activities over the past decade on pain management and treating substance use disorder.
H-165.836	Government Health Care Czars' Accountability	Our AMA will pursue all regulatory or legislative action in proposed health system reform legislation and regulations to assure accountability, an appeal process and judicial review for decisions made by healthcare officials charged with the responsibility of decisions related to patients and providers of health care. Citation: (Res. 209, A-10)	Rescind – This policy has been accomplished by passage of the Affordable Care Act.
H-180.988	Federal Policy Favoring HMOs	Our AMA supports legislation amending the current federal law so that employers must offer multiple options for health care benefits to employees or to their union representatives, including the traditional fee-for-service coverage option, if a health care benefit is provided. Citation: (Sub. Res. 43, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-190.957	Free Electronic Claims Billing	Our AMA: (1) supports the ability of physicians to submit claims directly to payors, either electronically or by mailing paper claims; and (2) opposes clearinghouses that inappropriately charge physicians for claim submission, alter codes, or otherwise inappropriately reduce reimbursements. Citation: (Res. 702, A-10)	Retain in part, with the following modification: Our AMA: (1) supports the ability of physicians to submit claims directly to payors, either electronically or by mailing paper claims; and (2) opposes clearinghouses that inappropriately charge

			physicians for claim submission, alter codes, or otherwise inappropriately reduce reimbursements. Citation: (Res. 702, A-10)
H-190.963	Identity Fraud	Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation. Citation: (Res. 805, A-01; Reaffirmed: Res. 804, A-02; Reaffirmation A-10)	Retain – This policy remains relevant.
H-220.929	Use of Ongoing Professional Practice Evaluation Data	Our AMA advocates that Ongoing Professional Practice Evaluation (OPPE) data be considered as peer review information and therefore be afforded protections under relevant state and federal law, and not be used for economic credentialing purposes. Citation: (Sub. Res. 821, I-10)	Retain – This policy remains relevant.
H-230.995	Medical Liability Insurance Coverage as Mandatory Requirement for Hospital Staff Appointment	1. Each hospital medical staff should determine for itself whether or not it will require professional liability insurance coverage as a condition for membership on the hospital medical staff. 2. Our AMA also believes that, if equity demands that voluntary staff members should have insurance coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate insurance or protected financially through self-insurance mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff. 3. Our AMA will seek federal legislation that would amend the federal bankruptcy code such that medical liability premiums that are contractually paid by a hospital on behalf of physician employees shall be considered a priority claim in bankruptcy filings and paid immediately out of the proceeds of the bankrupt hospital's estate. Citation: (BOT Rep. T, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-03; Reaffirmation A-04; Appended: Res. 230, I-10)	Retain – This policy remains relevant.
H-270.975	Cost Effectiveness of Legislation Regulating Medicine	The AMA will seek legislation to require a cost effectiveness study, including evaluation of the effects on the delivery of high quality patient care services, before congressional passage of any future legislation regulating the medical profession. Citation: (Res. 235, I-92; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-270.980	Independent Health Policy Advisory Council	Our AMA believes that yet another national health advisory body would be redundant and that the AMA should not sponsor legislation at the national level that would provide for an independent health policy advisory council. Citation: (BOT Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – This policy is no longer relevant.

H-270.982	Truth in Advertising Standards for Managed Health Care Plans	It is the policy of the AMA to seek legislation which would provide that managed health care plans meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification and concurrent review practices. Citation: (Res. 220, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-270.997	Legal Restrictions on Sexual Behavior Between Consenting Adults	Our AMA supports in principle repeal of laws which classify as criminal any form of noncommercial sexual conduct between consenting adults in private, saving only those portions of the law which protect minors, public decorum, or the mentally incompetent. Citation: (BOT Rep. I, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-275.963	Mandatory Medicare Assignment or Determination of Fee Levels	Our AMA supports federal legislation that would prohibit states from enacting legislation to require that acceptance of Medicare assignment or the Medicare allowance of reimbursement be a condition of medical licensure, or used in determinations of unprofessional conduct, or made effectively mandatory in any other fashion. Citation: (Sub Res. 75, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Reaffirmation I-10)	Retain – This policy remains relevant.
H-275.984	Legislative Action	The AMA (1) vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount; (2) strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and (3) opposes any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure. Citation: (Sub. Res. 117, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmation I-10)	Retain – This policy remains relevant.
H-275.995	Physician Membership on State Boards of Medicine	Rather than developing a model Medical Practice Act, our AMA supports providing continued assistance in the drafting of Medical Practice Act provisions by working individually with each state medical association desiring such assistance. Citation: (BOT Rep. Q, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.

H-290.989	Access to Care by Medicaid Patients	Our AMA (1) requests CMS to improve Medicaid patients' access to care by considering physicians' costs in its determinations regarding the cost effectiveness of Medicaid third party liability requirement; and (2) will work with CMS and/or Congress to allow state Medicaid agencies to waive the requirement that physicians pursue third party payments prior to seeking payment from Medicaid. Citation: (Res. 225, I-92; Appended: Res. 201, A-00; Modified: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-320.951	AMA Opposition to "Procedure-Specific" Informed Consent	Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure. Citation: (Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-330.892	Medicare Participation Status	It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status. Citation: (Res. 104, A-10)	Retain – This policy remains relevant.
H-330.910	Congressional Oversight Hearings and Legislative Reform of CMS	Our AMA will: (1) seek immediate and periodic Congressional oversight hearings of the CMS on issues related to the administration of the Medicare and Medicaid programs and additionally will seek legislation to reform CMS; and (2) undertake and support activities that would hold state and federal agencies, their contractors, and employees dealing with health care issues to the same level of accountability as are physicians. Citation: (Sub. Res. 207, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-340.949	Repeal/Modification of OBRA 1989	It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General. Citation: (Res. 214, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – This policy focuses on PROs, which were replaced by QIOs. AMA has policy superseding this one on QIOs, including Quality Improvement Organization Program Status H-340.901 and Quality Improvement Organization Status H-340.903.
H-345.991	Psychologists' Admitting Privileges	The AMA encourages state medical associations to oppose legislation or regulations granting hospital admitting privileges to psychologists. Citation: (Sub. Res. 205, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 23, A-09)	Retain – This policy remains relevant.
H-373.996	Exclusion of Medical Debt That Has Been Fully Paid or Settled	Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner. Citation: (Res. 226, I-10)	Retain – This policy remains relevant.

H-390.910	Repeal of Portions of Catastrophic Coverage Act of 1988	It is the policy of the AMA to continue to work to effect legislation to repeal those portions of any law or regulation that would require that CMS include information in every Explanation of Benefits form for unassigned claims on how Medicare assignment would have affected nonassigned claims. Citation: (Sub. Res. 63, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-390.994	Government Regulations	Our AMA vigorously opposes regulations and legislation which would: (1) interfere with and/or redefine the practice of medicine; (2) substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients; (3) base physician reimbursement on any system which does not give recognition to knowledge, skill, time and effort; or (4) otherwise impinge significantly upon the practice of medicine. Citation: (Sub. Res. 28, I-82; Amended: CLRPD Rep. A, I-92; Reaffirmed by Sub. Res. 203, A-98; Reaffirmation A-00; Reaffirmation I-01; Reaffirmed: Res. 704, A-10)	Retain – This policy remains relevant.
H-40.968	Health Care Coverage for Children of Military Families	Our AMA supports legislation that would provide coverage for military children under TRICARE, consistent with coverage afforded to children under non-grandfathered private health plans. Citation: (Res. 218, I-10)	Retain – This policy remains relevant.
H-40.981	Liability Insurance Costs Caused by Military Service	Our AMA supports petitioning Congress, the President, and other relevant authorities to seek appropriate amendments to the ~~Soldiers and Sailors Relief Act~~ Servicemembers Civil Relief Act in order to provide adequate professional liability protections for physicians called to active military duty. Citation: (Sub. Res. 133, I-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain in part. This policy remains relevant but should be modified to reflect a change in the name of the statute cited in this policy.
H-40.996	Appointment of Assistant Secretary of Defense for Health Affairs	Our AMA believes that the U.S. President should nominate a physician experienced in military medicine for appointment as Assistant Secretary of Defense for Health Affairs. Citation: (Res. 123, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)	Retain – This policy remains relevant.
H-40.998	~~Variable~~ Incentive Pay Programs for Physicians in Military Service	Our AMA, through letters to the President and appropriate members of the Congress and through such other means as are appropriate, strongly supports ~~timely re-enactment of the Variable I~~incentive ~~P~~pay ~~P~~programs for physicians in military service. Citation: (Res. 91, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)	Retain in part. The term "Variable Incentive Pay Program" is outdated and should be updated to apply to incentive pay programs more generally.
H-420.957	Shackling of Pregnant Women in Labor	1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints	Retain – policy remains relevant.

		necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents: - An immediate and serious threat of harm to herself, staff or others; or - A substantial flight risk and cannot be reasonably contained by other means. If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used." 2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. Citation: Res. 203, A-10	
H-460.969	Biomedical Research Protection	Our AMA: (1) encourages state medical associations to support legislation which would amend current criminal codes to specifically state that the unauthorized removal of research animals and/or damage to research projects/facilities is a crime, and the minimum penalty for this offense shall be a felony; and (2) supports passage of the intent of the Federal Animal Research Facilities Protection Act of 1989 (S 727) as originally proposed by Senator Heflin (D-Alabama). Citation: (Res. 251, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-480.996	Medical Device Amendments of the FDA	(1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records' confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.	Retain – This policy remains relevant.

		Citation: (Res. 146, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	
H-510.994	Ethics Reform Act of 1989 (PL 101194)	It is the policy of the AMA to work with representatives of [the] Central Office, Department of Veterans Affairs, to develop provisions to exclude either by regulation or by legislation part-time Department of Veterans Affairs physicians (as well as attending and consulting physicians) from the provisions of the Ethics Reform Act of 1989. Citation: (Res. 254, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-65.971	Mental Illness and the Right to Vote	Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness. Citation: (Res. 202, A-10)	Retain – This policy remains relevant.

APPENDIX 2

AMA Policies Superseding Policies Recommended for Rescission

Policy D-130.994, "Limit Scope of EMTALA to Original Legislative Intent"
(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement. (2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose. (3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting.
Sub. Res. 217, I-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-130.950, "Emergency Medical Treatment and Active Labor Act" (EMTALA)
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;
(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;
(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and. (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.
Sub. Res. 214, A-97 Reaffirmation I-98 Reaffirmation A-99 Appended: Sub. Res. 235 and Reaffirmation A-00 Reaffirmation A-07 Reaffirmed: BOT Rep. 22, A-17

Policy D-130.982, "EMTALA -- Major Regulatory and Legislative Developments"
Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
BOT Rep. 17, I-02 Reaffirmation A-07 Modified: BOT Rep. 22, A-17

Policy D-130.971, "The Future of Emergency and Trauma Care"
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have

delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.
BOT Rep. 14, I-06 Reaffirmation A-07 Reaffirmation A-08 BOT action in response to referred for decision Res. 204, A-11 Appended: Res. 221, I-11 Modified: CCB/CLRPD Rep. 2, A-14

Policy D-185.998, "Litigation Regarding Patient Care Guidelines"
Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines.
BOT Rep. 4, I-00; Reaffirmed: BOT Rep. 6, A-10

Policy H-373.995, "Government Interference in Patient Counseling"
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.
Res. 201, A-11Reaffirmation: I-12Appended: Res. 717, A-13Reaffirmed in lieu of Res. 5, I-13Appended: Res. 234, A-15Reaffirmation: A-19

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

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

Policy D-385.981, "Increased Administrative Fees for Multivalent Vaccines"
Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population.

Res. 731, I-02 Reaffirmation I-10

Policy D-440.981, "Appropriate Reimbursements and Carve-outs for Vaccines"
Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for **vaccine** services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular **vaccine**; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on **vaccine** recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physicians office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.
BOT Rep. 20, A-03 Reaffirmation A-07 Res. 128, A-09 Reaffirmation I-10 Reaffirmed: Res. 807, I-11 Appended: Res. 217, A-19

Policy D-390.960, "Assuring Patients' Continued Access to Physician Services"
1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010.
2. Our AMA is committed to a well funded and priority legislative and grassroots campaign to ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's "Medicare Patient Empowerment Act" as the centerpiece legislation the AMA supports.
3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation.
Citation: Sub. Res. 204, A-10; Appended: Res. 202, I-10

Policy D-390.957, "A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act"
Our AMA will now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the 2010 Interim Meeting of the House of Delegates through AMA Policy D-390.960.
Res. 203, I-11

Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform"
1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:
A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
B. Repeal and appropriate replacement of the SGR;
C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.
2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.
3. There will be a report back at each meeting of the AMA HOD.
Res. 231, A-13Reaffirmed in lieu of Res. 215, A-15Reaffirmation: A-17

Policy D-380.997, "Private Contracting by Medicare Patients"
1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry.
2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.
3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.
CMS Rep. 6, A-99Reaffirmation A-04Reaffirmation A-08Reaffirmation I-13Modified: CMS Rep. 1, A-15Reaffirmed: Res. 217, I-16

Policy H-383.991, "Right to Privately Contract"
Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; (2) the restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans.
Res. 203, A-09Reaffirmed: BOT Rep. 09, A-19

Also see: BOT Report 11-A-11 - Effective AMA Action to Preserve Medicare Benefits for Patients.

Policy D-478.999, "Guidelines for Patient-Physician Electronic Mail"
The BOT revisit "Guidelines for Patient-Physician Electronic Mail" when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented.
BOT Rep. 2, A-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging"
New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.
(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.
Communication Guidelines:
(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
(b) Inform patient about privacy issues.
(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject

matter (HIV, mental health, etc.) permitted over e-mail.
(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
(g) Request that patients put their name and patient identification number in the body of the message.
(h) Configure automatic reply to acknowledge receipt of messages.
(i) Send a new message to inform patient of completion of request.
(j) Request that patients use autoreply feature to acknowledge reading clinicians message.
(k) Develop archival and retrieval mechanisms.
(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
(q) Remind patients when they do not adhere to the guidelines.
(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.
Medicolegal and Administrative Guidelines:
(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
(b)Terms in communication guidelines (stated above).
(c) Provide instructions for when and how to convert to phone calls and office visits.
(d) Describe security mechanisms in place.
(e) Hold harmless the health care institution for information loss due to technical failures.
(f) Waive encryption requirement, if any, at patient's insistence.
(g) Describe security mechanisms in place including:
(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
(j) Never using patient's e-mail address in a marketing scheme.
(k) Not sharing professional e-mail accounts with family members.
(l) Not using unencrypted wireless communications with patient-identifiable information.
(m) Double-checking all “To” fields prior to sending messages.
(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
(o) Commit policy decisions to writing and electronic form.
(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.
(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.
BOT Rep. 2, A-00 Modified: CMS Rep. 4, A-01 Modified: BOT Rep. 24, A-02 Reaffirmed: CMS Rep. 4, A-12 Modified: BOT Rep. 11, A-17 Reaffirmation: I-18

Policy H-340.949, “Repeal/Modification of OBRA 1989”
It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General.
Res. 214, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-340.901, “Quality Improvement Organization Program Status”
1. Our AMA strongly urges CMS to require that Medicare Quality Improvement Organizations (QIOs) adhere to the following principles: (a) physicians should be provided with the fundamental principles of fairness and

due process throughout QIO proceedings; (b) all appeal mechanisms available to physicians should be exhausted before QIOs disclose their decisions to beneficiaries; (c) the language used in QIO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and (d) QIOs should be required to receive affirmative physician consent before patients are notified of QIO review determinations.
2. Our AMA will advocate to: (a) change the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict; (b) require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise; and (c) require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed.
CMS Rep. 7, I-96 Reaffirmed: CMS Rep. 16, I-98 Reaffirmation A-01 Reaffirmed: CMS Rep. 7, I-01 Modified: CMS Rep. 7, A-11 Appended: Res. 224, I-18

Policy H-340.903, "Quality Improvement Organization Status"
The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector.
CMS Rep. 9, I-95 Reaffirmed and Modified with change in title: CMS Rep. 7, A-05 Reaffirmed: CMS Rep. 1, A-15

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1, June 2020

Subject:	CEJA's Sunset Review of 2010 House Policies—Updated
Presented by:	Kathryn L. Moseley, MD, Chair
Referred to:	Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- Each year the House policies that are subject to review under the policy sunset mechanism are identified.
- Policies are assigned to appropriate Councils for review.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent and like policy. A justification must be provided for the recommended action to retain a policy.
- A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates resets the sunset clock, making the reaffirmed or amended policy viable for another 10 years.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

2010 POLICIES

In this report, the Council on Ethical and Judicial Affairs (CEJA) presents its recommendations regarding the disposition of 2010 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint Report I-01 and of subsequent reports of CEJA's sunset review of House policies, this report recommends the rescission of House policies issued since June 2010. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. When a CEJA Opinion responding to a resolution from the House of Delegates is issued, the corresponding House policy is rescinded.

The Appendix provides recommended actions and their rationale on House policies from 2010, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500.

APPENDIX - RECOMMENDED ACTIONS

Policy No.	Title	Recommended Action & Rationale
D-140.991	Continuing Efforts to Exclude Physicians from State Executions Protocols	Reaffirm.
D-235.989	Strengthening Medicare Requirements on Self-Governance Our AMA will take all appropriate steps to (1) seek federal regulatory and/or statutory changes to strengthen a medical staff's right to **self-governance** to ensure that the medical staff as a whole is responsible for the patient care, patient safety, and the quality of care delivered in the hospital; (2) seek federal statutory and/or regulatory changes as necessary to ensure that the **Medicare** program has the ability to, and does in fact, enforce **Medicare** conditions of participation relating to the organized medical staff. (2008)	Rescind. Duplicative and outdated. Policy is largely incorporated into other newer provisions at this time.
D-235.994	Medical Staff Autonomy and Self-Governance	Reaffirm.
D-255.995	Discrimination Against IMGs in Classified Advertising	Reaffirm
D-35.999	Non Physicians' Expanded Scope of Practice (Laboratory Testing and Test Interpretation)	Reaffirm.
H-140.854	Responsible Biomedical and Bioethics Journalism	Reaffirm.
H-215.985	Child Care in Hospitals	Reaffirm.
H-215.999	Denial of Hospital Service Resultant from Labor Discord Our AMA encourages hospitals to take all reasonable measures to resolve labor disputes expeditiously so that citizens of the community are not deprived of essential medical service. (1975)	Rescind. Policy is duplicative of E-1.2.10 Political Action by Physicians. E-1.2.10 also discusses the rationale of this guidance.
H-235.965	Physician Involvement in Hospital or Health Care Corporate Compliance Committees Concerning Fraud and Abuse	Reaffirm.
H-265.993	Peer Review of Medical Expert Witness Testimony AMA policy is that: (1) the giving of medico-legal testimony by a physician expert witness be considered the practice of medicine, and (2) all medico-legal expert witness testimony given by a physician should be subject to peer review. (1997)	Reaffirm.
H-265.995	Guidelines for Expert Witness The AMA supports (1) continued study of the various state and specialty society expert witness guidelines that are available, and (2) again disseminating its model state legislation establishing expert witness guidelines and working with the American Bar Association to achieve passage of the guidelines embodied therein. (1991)	Reaffirm.

H-275.951	Mandatory Acceptance of Patient's Group Plan It is the policy of the AMA that the sole purpose of medical licensure is to assure the competence of physicians to practice medicine.	Rescind. Policy is outdated; “group plan” is no longer relevant terminology.
H-280.968	Do Not Hospitalize Orders	Reaffirm.
H-295.996	Psychological Testing Without Informed Consent	Reaffirm.
H-295.998	Due Process (1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights." (2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.(1979)	Reaffirm. NOTE: LCME language has been updated. H-295.998 should be edited as follows: Due Process (1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: ~~"A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights."~~ “The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters.”
H-30.970	The Use of AMA Funds for the Purchase of Alcohol	Reaffirm
H-315.970	Personal Health Records	Reaffirm
H-315.971	Patient Information in the Electronic Medical Record	Rescind.

	AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:	This policy is no longer relevant as it predates HIPAA. Further, confidentiality in this context is extensively discussed in more recent AMA policy.
H-320.979	Potential Breaches of Confidentiality Resulting from Third Party Payers' Requests for Patient Information	Rescind. This policy is no longer relevant as it predates HIPAA. Further, confidentiality is extensively discussed in more recent AMA policy.
H-320.994	Confidentiality	Rescind. This policy is no longer relevant as it predates HIPAA. Further, confidentiality is extensively discussed in more recent AMA policy.
H-350.971	AMA Initiatives Regarding Minorities	Reaffirm.
H-350.975	Improving Healthcare of Hispanic Populations in the United States	Reaffirm.
H-375.960	Protection Against External Peer Review Abuses	Reaffirm.
H-375.961	Protection of Performance Evaluations of Residents and Fellows During Litigation Our AMA opposes the utilization of resident and fellow performance evaluations: (1) for any purpose other than providing educational feedback; and (2) in connection with litigation. (BOT 29-A-10)	Reaffirm.
H-40.984	Physician Reservists	Reaffirm
H-405.981	Professional Autonomy	Reaffirm.
H-405.985	Truthful Specialty Information Our AMA: (1) reaffirms its policy that: (a) individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; (b) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria; (c) a physician who acquires new skills as a result of additional education or training should be given individual evaluation and the same consideration as a new physician applying for privileges; and (2) believes that advertising by physicians should comply with ethical opinion 5.02 of the Council of Ethical and Judicial Affairs. (1989)	Reaffirm. NOTE: Ethical opinion cited has been updated and should be 9.6.1, as noted below: (2) believes that advertising by physicians should comply with ethical opinion ~~5.02~~ 9.6.1 of the Council of Ethical and Judicial Affairs.
H-405.994	Exemption of Physicians from Jury Service	Reaffirm
H-405.998	Opposition to the Concept of Withholding Medical Services	Rescind. This policy is duplicative of E-1.2.10 Political Action by Physicians

H-406.996	Use and Release of Physician-Specific Health Care Data	Reaffirm.
H-460.945	Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence Our AMA will: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats, and stalking; (2) support increased national, state, and local protection for physicians and other personnel providing health care services or engaged in biomedical research; and (3) develop model state legislation that defines "stalking" as a crime, and that includes adequate provisions relating to physicians and other health care personnel. (1993)	Rescind. The intent of this policy has been accomplished through criminal stalking laws which have been expanded to cover cyberstalking, a nonexistent threat at the time this policy was written. This resource also outlines both state and federal criminal and civil stalking laws, as well as military, & tribal policies.
H-460.966	Scientific Fraud and Misrepresentation	Reaffirm.
H-475.982	Surgical Safety Checklists	Reaffirm.
H-478.999	An International Code of Ethics for Internet Health Sites	Reaffirm.
H-5.992	Fetal Tissue Transplantation Research Our AMA (1) supports continued research employing fetal tissue obtained from induced abortion, including investigation of therapeutic transplantation; and (2) demands that adequate safeguards be taken to isolate decisions regarding abortion from subsequent use of fetal tissue, including the anonymity of the donor, free and non-coerced donation of tissue, and the absence of financial inducement. (1989)	Rescind. This policy has been superseded by E- 7.3.5 Research Using Human Fetal Tissue and E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors
H-5.994	Use of Fetal Tissue for Legitimate Scientific Research The AMA supports (1) the concept of the use of fetal tissue for legitimate scientific research, including transplantation; and (2) continued federal funding for such research. (1988)	Rescind. This policy has been superseded by E- 7.3.5 Research Using Human Fetal Tissue and E-6.2.1 Guidelines for Organ Transplantation from Deceased Donors
H-5.995	Abortion	Reaffirm.
H-65.970	Punitive Mutilation	Reaffirm.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1, June 2020

Subject:	Council on Medical Education Sunset Review of 2010 House of Delegates' Policies
Presented by:	Jacqueline A. Bello, MD, Chair
Referred to:	Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations. The current policy reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS ON 2010 AND OTHER RELATED HOUSE OF DELEGATES POLICIES

Policy Number, Title, Policy	**Recommended Action**

H-200.950, "Retraining Refugee Physicians"

Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories. (BOT Rep. 20, A-10)	Retain; still relevant.

H-200.959, "Support for the Funding of the National Health Service Corps"

The AMA supports the continuation of funding to the National Health Service Corps at least at the level originally appropriated in 1995. (Res. 241, A-95; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by D-200.980, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," which reads, in part: "1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations…." Also superseded by H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which reads, in part: "F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. "G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program."

H-200.984, "National Health Service Corps Reauthorization"

It is the policy of the AMA: (1) to support legislative efforts to revitalize and reauthorize the NHSC; and (2) to undertake efforts to assure that such legislation include increased funding for recruitment and retention efforts and adequate funding for both the loan repayment and scholarship programs.	Sunset; superseded by D-200.980, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," which reads, in part: "1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state

(Res. 120, A-90; Reaffirmed: Sunset Report and CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation I-15)	support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations…." Also superseded by H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which reads, in part: "F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. "G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program."

H-200.989, "National Health Service Corps"

The AMA believes that since a sufficient need for physician manpower is expected to continue to exist in certain areas of the U.S., continuation of assistance from the NHSC is justified. As long as this need continues, the AMA does not think it would be appropriate to deprive residents of certain areas of the U.S. of necessary medical services by diverting NHSC physicians to other countries. (CMS Rep. F, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; no longer relevant.

H-200.987, "Supply and Distribution of Health Professionals"

(1) Licensure, certification and accreditation should not be used for the purpose of regulating the supply of health professionals. (2) Health professions' curricula should emphasize the needs of underserved populations, including the poor, minorities, the chronically ill and disabled, and the geographically isolated. Decisions regarding the financing of health professions education should be based in part on the data and analyses of the national consortium on the supply and distribution of health professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Reaffirmation I-10)	Retain Clause 1, as it is still relevant; delete Clause 2. The first sentence of Clause 2 is superseded by H-295.874, "Educating Medical Students in the Social Determinants of Health and Cultural Competence." This policy should be revised to include mention of underserved populations, as follows: "Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, ~~and~~ cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum

	to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models." The second sentence of Clause 2 is no longer relevant: For example, a "national consortium on the supply and distribution of health professionals" does not currently exist.

H-215.987, "Elimination of Hospital Medical Library"

It is the policy of the AMA through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts which will maintain Health Sciences Libraries at a level which ensures adequate learning resources for the present and future. (Sub. Res. 24, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10)	Retain; still relevant, with edits as shown below. "~~It is the policy of~~ Tthe AMA should work, through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts ~~which will~~ to maintain Health Sciences Libraries at a level ~~which~~ that ensures adequate learning resources for the present and future."

H-220.996, "Private Patients and the Responsibility of the Attending Physician in a Teaching Hospital Setting"

Our AMA opposes mandatory delegation of diagnosis and treatment of private patients primarily to housestaff physicians in teaching hospitals and recommends that (1) refusal to delegate care of private patients to housestaff not be grounds for reduction or termination of privileges; (2) the patient's own private physician be responsible for his care; and (3) JCAHO assure that accreditation standards maintain the right of free choice by patients to have care provided by his own physician. (Sub. Res. 131, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. The Academic Physicians Section or another AMA section will be asked to review the policy and consider an updated version, if needed.

H-255.969, "Create Local Observership Programs"

Our AMA encourages physician preceptors, medical associations, and medical organizations to establish local observership programs by utilizing the IMG Observership Guidelines and Evaluation Tools. (Res. 307, A-10)	Retain; still relevant.

H-255.975, "J-1 Exchange Visitor Program (J-1 Visa)"

1. Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program. 2. Our AMA supports a model employment contract specific to J-1 Visa Waiver physicians. (CME Rep. 2, A-97; Modified and Reaffirmed: CME Rep. 2, A-07; Appended: Res. 304, A-10)	Retain; still relevant.

H-255.978, "Unfair Discrimination Against International Medical Graduates"

It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPlN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate	Retain; still relevant.

Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG. (Res. 123, I-90; Reaffirmation A-00; Reaffirmed: CME Rep. 2, A-10)	

D-255.997, "Alternate Licensure Protocols for IMGs"

Our AMA will actively support the Florida Medical Association in pursuing legislation that would require the Florida Department of Health to prevent and negate separate criteria for International Medical Graduates to become licensed as Florida physicians. (Res. 311, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; no longer relevant. This policy resulted from a resolution related to approximately 400 Cuban refugee physicians seeking to practice medicine in the U.S. (in Florida, in particular). As noted in a 2000 *New York Times* article, "To accommodate them, the Florida Legislature, at the urging of the Cuban-American Caucus, has established a separate test for this group, in the hopes of making it easier to pass. It has placed less emphasis on pure science and more on treatment and diagnosis, for example, and made special courses available to help these immigrants prepare for the test." Also, superseded by H-200.950, "Retraining Refugee Physicians": "Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories."

H-275.921, "Licensure for Physicians Not Engaged in Direct Patient Care"

Our AMA: (1) opposes laws, regulations, and policies that would limit the ability of a physician to obtain or renew an unrestricted state or territorial medical license based solely on the fact that the physician is engaged exclusively in medical practice which does not include direct patient care; (2) advocates that the Federation of State Medical Boards support provision of unrestricted state or territorial medical licenses to physicians engaged in medical practice that does not include direct patient care; (3) urges constituent state and territorial medical societies to advocate with their respective medical boards to establish policy that will facilitate provision of unrestricted state or territorial medical licenses to physicians in medical practice that does not	Retain; still relevant.

include direct patient care; and (4) opposes activities by medical licensure boards to create separate categories of medical licensure solely on the basis of the predominant professional activity of the practicing physician. (Res. 923, I-10)	

H-275.958, "Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools"

It is the policy of the AMA to use its representatives on key national medical education committees to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase. (Res. 289, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant, with edits as shown below, as AMA representatives to external medical education committees have a fiduciary responsibility to that organization, not to the AMA. "It is the policy of the AMA to ~~use its representatives on key national medical education committees to~~ encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase."

H-280.998, "Resident Medical Training in Nursing Homes for Geriatric Patients"

Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and resident training programs for the development of clinical experience in such facilities where feasible. (Sub. Res. 12, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but append to D-295.969, "Geriatric and Palliative Care Training For Physicians," to read as follows: "Our AMA: ~~will~~ 1) encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities; and 2) endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities."

H-295.873, "Eliminating Benefits Waiting Periods for Residents and Fellows"

Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and	Retain; still relevant.

(3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. (BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10)	

H-295.886, "Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior"

AMA policy is that the educational programs for medical students and resident physicians must include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training. (CME Rep. 3, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but append to D-295.983, "Fostering Professionalism During Medical School and Residency Training," to read as follows: "(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics. (b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism. (c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism. (d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism. "(2) Our AMA, along with other interested groups, will continue to study the clinical

	training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training."

H-295.957, "Use of Animals in Medical Education"

Our AMA has adopted the following guidelines on the use of animals in medical school curricula and continuing medical education courses: (1) Where appropriate, medical school faculty should consider using non-animal models in education activities; when animals are used in the curriculum, education goals should be clearly stipulated. (2) Each medical school should disseminate a policy statement to students before matriculation regarding their participation in educational experiences involving animals. (3) All educational experiences involving animals should have the approval of the institutional Animal Care and Use Committee. (4) Involved faculty should discuss with students the learning objectives of any educational experience that utilizes animals, and faculty should remain available throughout the laboratory exercise for advice and guidance on the conduct of the educational experience. (5) All educational experiences involving animals should be carried out in a humane manner without inflicting pain on the animal. This includes the appropriate use of anesthetic and analgesic drugs.	Retain; still relevant. Although now encompassed in research regulations and laws for animal care, it is appropriate for the AMA to maintain this ethical stance.

(6) At the conclusion of study, animals should be euthanized in the manner described by the American Veterinary Medical Association. (CSA Rep. A, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	

H-295.959, "Departments of Family Practice in all LCME Approved Medical Schools"

Our AMA urges the LCME to strongly encourage every medical school without a Department of Family Practice to develop one. (Res. 59, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant, with edits as shown below to policy and title. Although, as noted in a 2016 article in STAT, "only 10 medical schools in the nation … don't have a department of family medicine, according to the American Academy of Family Physicians," this list includes several prominent institutions, such as Harvard, Yale, Johns Hopkins, and Columbia. Note: The LCME does not encourage or mandate specific department structure, so it has been removed from the revision. In addition, the language of the policy's title has been revised for precision. "Departments of Family ~~Practice~~ Medicine in all LCME ~~Approved~~Accredited Medical Schools" "Our AMA urges ~~the LCME to strongly encourage~~ every medical school without a Department of Family ~~Practice~~ Medicine to develop one."

H-295.960, "Broadly Based Clinical Experience and Clinical Proficiency Standards"

It is the policy of the AMA: (1) to direct its representatives on the LCME to continue to monitor the educational content of the final year of educational programs accredited by the LCME so that the standards, and their application to accredited programs, will provide a broad clinical experience; and (2) to reaffirm existing policy that the first year of graduate medical education should provide the resident physician with a broad clinical experience. (CME Rep. H, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but superseded by other policies, as noted below. In addition, there are no AMA representatives to the LCME, and the LCME does not monitor programs' educational content. Clause 1 is superseded by H-295.895 (2), "Progress in Medical Education: Structuring the Fourth Year of Medical School," which reads: "(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training."

	Clause 2 is superseded by H-295.995 (19), "Recommendations for Future Directions for Medical Education," which reads: "(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training."

H-295.966, "Medical School Honor Codes"

Our AMA urges the LCME to facilitate the development of honor codes by medical schools. (CME Rep. D, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. The LCME doesn't "facilitate" this, and schools are required by LCME standards to define expectations for professional conduct. In addition, the LCME requires the creation of professionalism policies related to appropriate behavior on the part of students and faculty, which covers the same ground as an honor code.

H-295.968, "Training Physicians for the 21st Century"

Our AMA approves the concept of undertaking focused studies of medical education, with the participation of other appropriate organizations, at such time as adequate funding can be obtained. (CME Rep. D, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by the AMA's work through the Accelerating Change in Medical Education initiative.

H-295.977, "Socioeconomic Education for Medical Students"

1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula. 2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9. (CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 318, A-10)	Sunset; still relevant but superseded by the following policies (with proposed edits as shown). For clause 1: D-295.321, "Health Care Economics Education" "Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician's professional life, ~~starting in~~ including undergraduate medical education, graduate medical education and continuing medical education." For clause 2: H-310.953, "Practice Options and Skills Curriculum ~~for Residents~~ in Medical Education"

	"The AMA will assist medical societies, medical schools, and residency programs in the development of model curricula ~~for resident physicians and those entering practice~~ regarding practice options and management skills, including information on CPT and ICD coding, as well as RBRVS and RUC."

D-295.984, "Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior"

Our AMA will: (1) encourage research and collect information on methods for evaluating the objectives related to professional behavior, and share this information with the medical education community; and (2) offer to work with other organizations, such as the Association of American Medical Colleges, the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Federation of State Medical Boards, and the American Board of Medical Specialties, to develop methods and strategies for the evaluation of professional behavior. (CME Rep. 3, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; this is encompassed in the work of the AMA's Accelerating Change in Medical Education initiative.

H-300.953, "Content-Specific CME Mandated for Licensure"

(1) The AMA, state medical societies, specialty societies, and other medical organizations should reaffirm that the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. (2) State medical societies should establish avenues of communication with groups concerned with medical issues, so that these groups know that they have a place to go for discussion of issues and responding to problems. (3) State medical societies should periodically invite the various medical groups from within the state to discuss issues and priorities. (4) State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate. (CME Rep. 6, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 12, A-10)	Retain; still relevant.

H-300.976, "Unification of Education Credits"

It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. (Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-300.980, "Focused Continuing Education Programs for Enhanced Clinical Competence"

1. The AMA encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education. 2. The AMA encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs. 3. The AMA supports the collection and dissemination of information on focused continuing medical education programs that have been developed or are in the process of development. 4. Our AMA recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians' practice. (CME Rep. C, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 12, A-10)	Retain; still relevant.

H-300.994, "Support of Voluntary Continuing Medical Education"

Our AMA supports individual physician responsibility for self-education. (Res. 138, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 12, A-10)	Retain; still relevant.

H-300.996, "Reaffirmation of Support for Continuing Medical Education"

Our AMA supports investing funds in effective self-instructional educational programs that are within the budget and are potentially self-supportive. (Sub. Res. 122, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-300.997, "'Medical Education' Travel"

Our AMA (1) deplores excessive charges for continuing medical education programs which exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. (Sub. Res. 84, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-300.998, "Continuing Medical Education"

Our AMA continues to encourage physicians to voluntarily participate in continuing medical education. (Sub. Res. 13, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but superseded by H-300.994, "Support of Voluntary Continuing Medical Education," which reads, "Our AMA supports individual physician responsibility for self-education."

H-305.934, "Medical School Tuition and Opposition to Tax Increases"

1. Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools. 2. Our AMA opposes tuition taxes and any other attendance-based taxes by any government entity.	Sunset; still relevant, but append to D-305.983, "Strategies to Combat Mid-year and Retroactive Tuition Increases," to read as follows: "Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases,

(CME Rep. 2, I-02; Reaffirmed: CME Rep. 3, I-03; Appended: Res. 905, I-10)	tuition taxes, and any other attendance-based taxes by any government entity at both public and private medical schools; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students."

H-305.969, "Financial Information Requirements for Independent Medical Students"

Our AMA urges the HHS to abolish its requirement that independent students submit parental financial information when applying for financial assistance, consistent with the current policy of the Department of Education. (Sub. Res. 250, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; see the following information from the Student Financial Aid Guidelines for Health Professions Programs, related to the Primary Care Loan (PCL) Program (December 2011: "[T]he Affordable Care Act changed the parental financial information requirement for independent students who want PCLs [Primary Care Loans]. As of March 23, 2010, the requirement for independent students to provide parental financial information to determine financial need is eliminated. However, at its discretion, a school may still want to require parental financial information for independent students seeking a PCL. For this program, an independent student is defined as a student who is at least 24 years of age and can prove that he or she has been independent for a minimum of 3 years." [Section 5201(b) of the Affordable Care Act]

D-305.994, "Postgraduate Medical Education Reimbursement"

Our AMA: (1) will study the formula for funding graduate medical education that is used by Medicare, and make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula; and (2) policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated. (Sub. Res. 301, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. The AMA has frequently studied the Medicare formula for funding graduate medical education and continues to do so. The phrase "make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula" is superseded by D-305.967 (6), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads: "6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board

	certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)." Finally, clause 2, which asks that "policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated," is accomplished periodically through this report as well as other AMA Council and Board of Trustees' reports that consider medical education funding.

D-305.995, "Physician Workforce Planning and Physician Retraining"

(1) Our AMA will raise the awareness of groups using the model of adjusting entry-level residency positions to control the physician workforce of the substantial effect of retraining and changes in choice of specialty training on the number of filled entry-level positions. (2) Our AMA will collect data on access to health care by specialty and geographic location to assist in ongoing workforce planning initiatives. (3) A new model for workforce planning be developed to address the needs of the public for access to health care and the subsequent impact on the needs of teaching institutions to maintain the quality of their educational programs in considering the number of entry-level residency positions. (CME Rep. 2, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education." Relevant segments include: "18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes." "20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education." Also superseded by D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy." Relevant segments include the following: "4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages." "5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians."

H-305.999, "Financial Aid to Medical Students"

Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships to medical students. (Res. 6, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10)	Retain; still relevant.

H-310.914, "Appropriate Use of 360 Degree Evaluations"

Our AMA will: (1) encourage the Accreditation Council on Graduate Medical Education (ACGME) to study mechanisms used by residency programs to evaluate resident performance in the ACGME six general competencies, including 360-degree evaluation tools; and (2) encourage the ACGME to develop standards for the use of 360-degree evaluations, including a determination of their validity in resident assessment, and methods to ensure that the content of individual evaluations remains confidential and legally protected. (Res. 316, A-10)	Sunset; reflected in ACGME Common Program Requirements, as follows: V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members)….

H-310.915, "Securing Funding for Graduate Medical Education"

Our AMA will: (1) actively advocate for strong physician representation and significant participation in any proposed health-care workforce advisory committees, demonstration projects, or workforce assessments, since PL 111-148 calls for a "Health Workforce Commission"; (2) continue to advocate for adequate and sustained federal funding of pediatric residency programs independent of Medicare payments; and (3) encourage sponsors of graduate medical education (GME) training programs to use any refunded Federal Insurance Contributions Act (FICA) dollars they receive to enhance their GME training programs. CME Rep. 15, A-10	Sunset. Clause 1 is no longer relevant, as the proposed national health workforce commission of PL 111-148 (the Patient Protection and Affordable Care Act of 2010) was never funded. Clause 2 is superseded by D-305.973 (1.e), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which directs our AMA to work with "the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to… (e) stabilize funding for pediatric residency training in children's hospitals." Clause 3 is no longer relevant, as the refunded FICA monies have been distributed by the IRS. (In 2010, the IRS announced that medical residents may be eligible for a refund for the FICA (Social Security and Medicare) taxes withheld prior to April 1, 2005, and established a process by which refunds were requested by institutions on behalf of former residents.)

D-310.958, "Fellowship Application Reform"

1. Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less that 5 years, or in the final 2 years of residency for programs of 5 years or longer. 2. Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties. (CME Rep. 5, A-09; Appended: Res. 303, A-18)	Retain, still relevant, with minor edit as shown below. 1. Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less ~~that~~ than 5 years, or in the final 2 years of residency for programs of 5 years or longer. 2. Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties.

D-310.965, "Credentialing Materials: Timely Submission by Residency and Fellowship Programs"

1. Our AMA: (a) encourages residency programs and fellowship programs to properly complete and promptly submit verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request; and (b) encourages the Accreditation Council for Graduate Medical Education to add to the accreditation standards for residency and fellowship programs and to the Institutional Program Requirements the requirement of the proper completion and prompt submission of verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request. 2. Our AMA will work with the Federation of State Medical Boards, American Osteopathic Association and the Accreditation Council for Graduate Medical Education to develop a model form that residency programs can use to document resident performance, dates of participation, and any disciplinary measures imposed, to be maintained in the resident's	Sunset. Clause 1 is now part of the ACGME Common Program Requirements: The program director must: II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; Clause 2 has been accomplished, through development of the Verification of Postgraduate Medical Education form, available via the Federation of State Medical Boards website.

training file and used when future requests are submitted for evaluation of resident performance. (Res. 311, A-08; Appended: Sub. Res. 308, A-10)	

H-310.968, "Opposition to Centralized Postgraduate Medical Education"

Our AMA (1) continues to support a pluralistic system of postgraduate medical education for house officer training; and (2) opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools. (Res. 69, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. Clause 1 is superseded by D-305.967 (6), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads: "6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)." Clause 2 is no longer relevant, as (unlike in the late 1990s, when the initial resolution was drafted) there are no plans for "mandatory centralization" of GME in medical schools.

H-310.970, "Mandatory Helicopter Flight for Emergency Medical Residents in Training"

Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-310.972, "Residency Review Committee Representation and Requirements"

Our AMA (1) supports obtaining community practitioners representation on the Residency Review Committees (RRC); and (2) urges RRC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs. (Res. 219, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain, with edits as shown. Our AMA (1) supports obtaining community practitioners representation on ~~the Residency~~ ACGME Review Committees (~~R~~RCs); and (2) urges ~~R~~RC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs.

D-310.994, "Intern and Resident Work Standards"

Our AMA: (1) will support the various standards of Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committees as a template for reasonable resident work conditions, pending further data; and (2) will stress the consideration of patterns and trends of program violations of ACGME requirements, and affirm the recommendations of Council on Medical Education Report 3, A-00, that recommended various alternatives to enforce compliance with requirements, including the shortening of the cycle for review of programs that receive unfavorable Institutional Reviews. (Sub. Res. 306, I-00; Appended: CME Rep. 2, A-10)	Sunset; no longer relevant, and superseded by H-310.907, "Resident/Fellow Clinical and Educational Work Hours."

D-310.995, "Enforcement of ACGME Requirements"

(1) The ACGME be asked to distribute the alternatives suggested in this report to each of the Residency Review Committees (RRC) and the Institutional Review Committee for their consideration and comment as mechanisms to enforce compliance with requirements. (2) Our AMA representatives be requested to ask the ACGME and the RRCs to discuss mechanisms included in this report to enhance the enforcement of Institutional and Program Requirements without increasing the risk of the withdrawal of accreditation. (3) Our AMA representatives be requested to ask the ACGME and the RRCs to determine any additional information regarding program evaluations that can be added to the ACGME web site and that they encourage the ACGME to simplify that web site to facilitate the retrieval of information. (4) Our AMA, through the Medical Student Section and the Resident and Fellow Section, will provide medical students and residents a guide to interpreting the ACGME Web site as it relates to the various levels of accreditation and the length of the survey cycle. (CME Rep. 3, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; no longer relevant, and generally accomplished, in all likelihood.

D-383.996, "Impact of the NLRB Ruling in the Boston Medical Center Case"

Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations. (CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; the topic is still relevant, but this policy is superseded by other more relevant policies, including H-383.999 (2, 3), "Physician Negotiation," which notes: "2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act. "3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers." In addition, D-383.977, "Investigation into Residents, Fellows and Physician Unions," states that "Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment."

H-405.984, "Physician and Public Attitudes on Medicine as a Career"

Our AMA (1) supports continuation of its many efforts to address issues, such as professional liability and excessive regulation and interference by third parties, which contribute to the professional dissatisfaction expressed by some physicians; (2) supports continuation of its efforts to communicate to students, from elementary through college level, the rewards of a career in medicine, emphasizing the positive aspects of a career in medicine; (3) supports utilizing the Association's communications resources to make the 40 percent of the physician population who are dissatisfied with medicine as a career aware of the impact they are having on the career decisions of potential medical students and the	Sunset; the policy, which was originally adopted in 1989, has been superseded by and incorporated into AMA's multi-departmental work to promote the value of a career in medicine and enhance the joy of medical practice by addressing administrative and regulatory burdens that can lead to physician burnout.

implications that this has for the future of medicine; and (4) encourages the majority of physicians who feel positive about their career, and who understand that the profession is both challenging and rewarding, to aggressively convey, on a personal basis, their thoughts on the attributes of medicine as a career to students, the media, and other interested parties. (CLRPD Rep. D, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	

H-405.987, "Identification of Board Certified Physicians"

Our AMA urges physicians to identify themselves by stating the full name of their certifying board. (Res. 99, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant. This is reflected in the AMA's "Truth in Advertising" campaign, which notes the following (see page 13): "A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or 'board certified,' unless all of the following criteria are satisfied: (a) The advertisement states the full name of the certifying board…."

H-435.946, "Liability Coverage for Medical Students Completing Extramural Electives"

Our AMA: (1) supports the continuance of the AAMC online Extramural Electives Compendium (EEC) database as a resource for information on medical school electives, including liability insurance fees; and (2) will work with the AAMC to encourage medical schools to provide sufficient medical liability insurance for their own students completing electives at US Medical Doctor and Doctor of Osteopathy granting medical schools. (CME Rep. 9, A-10)	Retain; still relevant.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1, June 2020

Subject: Council on Medical Service Sunset Review of 2010 AMA House Policies

Presented by: W. Alan Harmon, MD, Chair

Referred to: Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after ten years unless action is taken by the House to re-establish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.

- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.

- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.

- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.

- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

The Council on Medical Service recommends that the policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of the report be filed. (Directive to Take Action).

Appendix
Recommended Actions on 2010 Socioeconomic Policies

Policy #	Policy Title	Recommended Action and Rationale
D-140.962	Hospice Services Under Medicare	Rescind. In 2010, the AMA distributed a briefing packet on hospice care and palliative medicine to key stakeholders within the Federation. The AMA also urged CMS to undertake the requested study in consultation with relevant national medical specialty societies. Additionally, Policies, H-85.951, H-85.955 and H-85.966 supersede the 2010 policy.
D-155.996	Health Care Expenditures	Retain. Still relevant.
D-165.984	Status Report On Expanding Coverage For The Uninsured	Rescind. Superseded by Policies H-165.824, H-165.828, H-165.920, H-165.851 and H-165.865.
D-165.986	Out of Pocket Expenses in an Individually Selected and Owned Health Insurance System	Rescind. Superseded by Policy H-385.926.
D-165.993	Federal Tax Legislation	Rescind. Superseded by Policy H-165.920.
D-190.996	ERISA and Health Plan Related Legislation	Retain. Still relevant.
D-225.995	Hospital Merger Study	Retain. Still relevant.
D-330.943	Physician Input in MAC Contracting Process	Retain. Still relevant.
D-330-974	Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director	Retain. Still relevant.
D-330.989	Medicare Coverage for Low Molecular Weight Heparin	Retain. Still relevant.
D-335.996	Status Report on Medicare Review Activities	Retain. Still relevant.
D-355.998	National Practitioner Data Bank	Retain. Still relevant.
D-385.993	Medicare Global Surgical Guidelines	Retain. Still relevant.
D-478.990	Clinical Information Technology Assistance	Retain. Still relevant.
D-480.984	Physician Information on Third Party Payer Performance	Rescind. The AMA dissolved the Private Sector Advocacy unit in mid-2013, and the activities referred to in this policy were performed by that unit. Moreover, the National Health Insurer Report Card, which evaluated major national health plans on metrics including time to payment, correct payment rate, appeals, etc. was last published by the AMA in 2013. There is no longer a business

Policy #	Policy Title	Recommended Action and Rationale
		unit at the AMA that performs this type of work due to changing organizational priorities.
D-510.993	Availability of Veterans Affairs Pharmacy Benefit	Retain. Still relevant.
D-70.987	Appropriate Use of Component Codes in Current Procedural Terminology (CPT)	Retain. Still relevant.
D-70.991	Insurers Excessive Documentation Requirements and Claims Submission	Retain. Still relevant.
D-70.993	Reimbursement for Telephonic and Electronic Communications	Retain. Still relevant.
H-125.991	Drug Formularies and Therapeutic Interchange	Retain. Still relevant.
H-130.960	Payment for Emergency Visits	Rescind. The AMA is no longer engaged in efforts on this issue.
H-130.961	Refusal of Appropriate Patient Transfers	Retain-in-part. Change "~~Principles of Appropriate Interhospital Patient Transfer~~" to "Appropriate Interfacility Patient Transfer" to reflect the title of the guidelines.
H-130.964	Federal Patient Transfer Laws	Retain-in-part. Rescind (1) as no longer timely since EMTALA was promulgated in 2009 and last amended in 2013. Policy should be amended to read: H-130.964 Federal Patient Transfer Laws ~~(1) It is the policy of the AMA to do whatever is appropriate to modify the new regulations of Federal Patient Transfer so that (a) an appropriate reporting mechanism is developed for those physicians who were on-call and did not respond in a reasonable period of time to stabilize patients in an emergency setting and (b) it is not necessary to include the name and address of said physician in a transfer record to another facility. (2)~~ The AMA urges physicians and component medical associations to collect and submit to the AMA reports on physician willingness to serve on Emergency Department on-call panels. (Res. 275, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)
H-130.965	Refusal of Appropriate Patient Transfers	Retain. Still relevant.
H-130.966	Federal Hospital Patient Transfer Amendments	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-130.968	Confusion Between Inappropriate Patient Transfer and Appropriate Patient Transfer	Retain. Still relevant.
H-130.972	Unfair CMS/OIG Review and Sanction Process for Hospital Emergency Room Care and Patient Transfers	Retain-in-part. Change references to "emergency room" in the title and body to "emergency department" to reflect modern terminology. Policy should be amended to read: H-130.972 Unfair CMS/OIG Review and Sanction Process for Hospital Emergency Department ~~Room~~ Care and Patient Transfers Our AMA supports modification of inadequate procedures utilized by CMS and the OIG in decertifying hospitals for "noncompliance" with the Medicare Conditions of Participation, particularly as they are being applied to hospital emergency department ~~room~~ Care room care issues. (Res. 88, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10)
H-130.973	Federal Emergency Transfer/"Anti-Dumping" Law	Retain. Still relevant.
H-130.982	Transfer of Emergency Patients	Retain-in-part. Change "~~Guidelines for Transfer of Patients~~" to "Policy Statement entitled 'Appropriate Interfacility Patient Transfer'" to reflect the title of the guidelines.
H-140.983	Hospital Medical Staff and Joint Ventures Oversight Committees	Retain. Still relevant.
H-160.916	Payment for Care Provided by US Physicians to Foreign Medical Evacuees	Retain. Still relevant.
H-165.837	Protecting the Patient-Physician Relationship	Retain. Still relevant.
H-180.949	Health Insurance Safeguards	Retain. Still relevant.
H-180.995	Government Subsidies to HMOs	Rescind. Superseded by Policy H-165.985.
H-185.947	Insurance Underwriting Reform	Rescind. Superseded by Policies H-165.838 and H-165.856.
H-185.965	Insurance Coverage of Periodic Health Care Services	Retain. Still relevant.
H-185.979	Allocation of Health Services	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-185.984	Toll-Free 24-Hour Insurance Information	Retain with minor editorial change. Still relevant. Correct editorial errors so that the policy be modified to read: (3) Our AMA seeks legislation to require that, where a plan does not provide toll-free, 24-hour access to verify patient coverage eligibility, the patient's identification card from the plan will ~~with~~ be deemed valid.
H-185.986	Nondiscrimination in Health Care Benefits	Retain. Still relevant.
H-185.987	Prayer Fees Reimbursed As Medical Expenses	Retain. Still relevant.
H-185.988	High Cost Health Benefits Management	Retain. Still relevant.
H-185.996	Utilization in Appropriate Settings	Rescind. Superseded by Policies H-285.951 and H-285.998.
H-205.997	AMA Statement on Voluntary Health Planning	Retain. Still relevant.
H-205.999	Cost Effectiveness of State Certificate of Need Programs	Retain. Still relevant.
H-210.979	Physician Responsibility for Nursing Agencies	Retain. Still relevant.
H-210.998	Home Health Service Abuse	Retain. Still relevant.
H-220.958	The Joint Commission Professional and Technical Advisory Committees	Rescind. These professional and technical advisory committees no longer exist.
H-220.960	The Joint Commission Hospital Accreditation Program Standards	Retain-in-part. Remove “that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges,” as it conflicts with Policy H-230.986. Policy should be amended to read: H-220.960 The Joint Commission Hospital Accreditation Program Standards Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws~~; that physician directors of hospital departments be board certified or possess~~

Policy #	Policy Title	Recommended Action and Rationale
		~~equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges~~; and that any changes to the hospital accreditation program standards occur only after a full, thorough and deliberative process, including a full field review of all proposed changes to the hospital accreditation program standards. (Res. 153, I-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10)
H-225.961	Medical Staff Development Plans	Retain-in-part. The AMA has accomplished its communications and recommendations regarding the medical staff development plan principles. Policy should be amended to read: H-225.961 Medical Staff Development Plans ~~1.~~ All hospitals/health systems incorporate the following principles for the development of medical staff development plans: … ~~2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.~~ (BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation A-10)
H-225.975	Compensation for the Medical Staff for Committee Work	Retain. Still relevant.
H-225.977	Liability Coverage for Physician Members of Hospital Committees	Retain. Still relevant.
H-225.979	Hospital Medical Staff Relationships - Dispute Resolution	Retain. Still relevant.
H-225.983	Physician Representation on Hospital Governing Boards	Retain. Still relevant.
H-230.960	Privileging for Ultrasound Imaging	Retain. Still relevant.
H-230.978	Physician Assignment	Retain. Still relevant.
H-230.979	Medical Staff Credentialing Verification	Retain. Still relevant.
H-230.998	Hospital Privileges	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-235.966	CMS Regulation to Eliminate the Critical Role of the Hospital Medical Staff	Rescind. The proposal to eliminate 42 CFR 482.22 was made approximately ten years ago and has not re-surfaced. Should another attempt to eliminate the critical role of the medical staff ever be made, the AMA would be strongly in opposition, and Policy H-235.966 would not be needed to take that opposing role in the future.
H-235.990	Organized Self-Governing Medical Staff	Retain. Still relevant.
H-235.991	Medical Staff Bylaws	Retain. Still relevant.
H-240.969	Medicare Social Admissions	Rescind. Superseded by Policies D-160.931 and D-160.932.
H-240.970	Reimbursement to Rural Hospitals for Patients Returning from Tertiary Care Centers	Retain. Still relevant.
H-240.971	Elimination of Payment Differentials Between Urban and Rural Medical Care	Retain. Still relevant.
H-240.999	Relationship of Hospital Costs and Hospital Charges	Retain. Still relevant.
H-275.994	Physician Participation in Third Party Payer Programs	Retain. Still relevant.
H-280.949	Caring for Group Home Residents	Retain. Still relevant.
H-280.967	Nurse Practitioner Reimbursement in Nursing Facilities	Retain. Still relevant.
H-280.984	Residential Facility Regulations	Retain. Still relevant.
H-285.962	Anti-Psychiatry Practices of Certain Health Maintenance Organizations and Managed Care Organizations	Retain. Still relevant.
H-315.991	Mandatory Computerization of Patient Records	Retain. Still relevant.
H-320.970	Private Insurer's Medical Review Policy	Retain. Still relevant.
H-320.971	Third Party Payers and Patient Care Standards	Retain. Still relevant.
H-320.972	Problems with Review Entities	Retain. Still relevant.
H-320.976	Medical Necessity of Diagnostic Tests	Retain. Still relevant.
H-330.909	Medicare Coverage for Low Molecular Weight Heparin	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-330.971	Medicare Policy on Inpatient Rehabilitation	Retain. Still relevant.
H-330.981	Hospital Responsibility for Diagnostic Reports	Retain. Still relevant.
H-340.902	The New Role of PROs in Quality Improvement	Retain. Still relevant.
H-340.940	Quality Improvement Organization Program Status	Retain. Still relevant.
H-345.987	CPT Codes for Medical Management of Mental Illness for Outpatients	Retain. Still relevant.
H-375.979	Litigation Over Hospital Peer Review Decisions	Retain. Still relevant.
H-375.982	Peer Review Defined as the Practice of Medicine	Retain. Still relevant.
H-375.999	Federal Hospital Utilization Review	Retain. Still relevant.
H-380.996	Voluntary Restraints of Physicians' Fee Increases	Retain. Still relevant.
H-380.997	Limitation of Physicians' Fees	Retain. Still relevant.
H-383.996	Restriction of Physicians from Performing Procedures by Managed Care Organizations	Retain. Still relevant.
H-385.933	Actuarially Sound Capitation	Retain. Still relevant.
H-385.934	Reimbursement for Office-Based or Outpatient Ultrasound Imaging	Retain. Still relevant.
H-385.990	Payment for Physicians' Services	Retain. Still relevant.
H-385.996	Support of the Concept of Cost Containment and Cost Effectiveness by Encouraging Patient Care in the Least Expensive Setting	Retain. Still relevant.
H-390.847	Deactivation of Medicare Billing Privileges - Lack of Appeal Rights and Harsh Adverse Effects on Physicians	Retain. Still relevant.
H-390.855	Replacement of Sustainable Growth Rate System	Rescind. No longer relevant. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed and replaced the Sustainable Growth Rate (SGR).

Policy #	Policy Title	Recommended Action and Rationale
H-390.857	Secondary Insurance Claims with Medicare Electronic Remittance Advice	Retain. Still relevant.
H-390.858	Medicare Coverage for Cardiovascular Stress Testing	Retain. Still relevant.
H-390.877	Home Health Care Services	Retain. Still relevant.
H-390.923	Purchased Diagnostic Tests	Retain. Still relevant.
H-390.925	Medicare Billing	Retain. Still relevant.
H-390.927	Rehabilitation Physician Visits	Retain with minor editorial change. Still relevant. To clarify that a visit per day is appropriate, based on medical necessity, but should not be required, when not medically necessary, the policy should be modified to read: Our AMA: (1) believes that a visit per day by the attending rehabilitation physician is appropriate, as medically necessary, for patients in certified acute inpatient rehabilitation units or facilities; and (2) supports communicating this position to CMS. (Sub. Res. 141, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10)
H-390.996	Medicare Reimbursement Policy	Retain. Still relevant.
H-390.998	Medicare Reimbursement Policy	Retain. Still relevant.
H-390.999	Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries	Retain. Still relevant.
H-415.987	Improper Discounts by Third Party Payers	Retain. Still relevant.
H-425.979	Coverage of Therapeutic Shoes as a Preventive Measure	Retain. Still relevant.
H-475.990	Physicians Credentialing	Retain. Still relevant.
H-510.995	Budgetary and Management Needs of the Veterans Health Administration	Retain. Still relevant.
H-55.975	Health Plan Coverage Policies for Anti-Nausea Regimens	Retain. Still relevant.
H-70.923	Conscious Sedation Reimbursement	Rescind. No longer relevant as the CPT/RUC successfully worked with specialty organizations to produce conscious sedation procedure codes eligible for reimbursement, in accordance with CPT coding guidelines and provider-appropriate CMS fee schedules.
H-70.927	Prevention of Misuse of Current Procedural Terminology (CPT)	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-70.931	Medicare Coverage for Cardiovascular Stress Testing	Retain. Still relevant.
H-70.952	Medicare Guidelines for Evaluation and Management Codes	Retain-in-part. Sections 5, 7 and 8 are no longer relevant following CPT 2021. The new Evaluation and Management descriptors and guidelines eliminate the single specialty examination component. Policy should be amended to delete Sections 5, 7 and 8, and renumbered accordingly.
H-70.954	Improper Use of AMA-CPT by Carriers/Software Programs	Retain. Still relevant.
H-70.961	Evaluation and Management Codes	Retain-in-part. The second clause is no longer relevant following CPT 2021. The new Evaluation and Management descriptors and guidelines eliminate the single specialty examination component. Policy should be amended to read: H-70.961 Evaluation and Management Codes Our AMA will work with the CMS to continue to refine evaluation and management coding~~; and will work with CMS to publish the specialty specific physical exam criteria in a timely fashion~~. (Res. 804, A-96; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)
H-70.976	Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding	Retain. Still relevant.
H-70.983	AMA Input to Diagnosis and Procedure Coding	Retain. Still relevant.
H-70.985	Preservation of Evaluation/Management CPT Codes	Retain. Still relevant.
H-70.987	Diagnostic Coding Requirements	Rescind. ICD-9 is no longer the standard.
H-70.989	ICD-9-CM Coding	Rescind. ICD-9 is no longer the standard.
H-70.990	ICD-9-CM Coding and Civil Money Penalties	Rescind. ICD-9 is no longer the standard.
H-70.992	CPT Coding	Retain. Still relevant.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1, June 2020

Subject: CSAPH Sunset Review of 2010 House of Delegates Policies

Presented by: Michael M. Miller, MD, Chair

Referred to: Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

At its 1984 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110, "Sunset Mechanism for AMA Policy"). Under this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the HOD modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following:

> (1) As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years. (2) In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii)Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.

In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the HOD policies from 2010 that were assigned to it. The CSAPH's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX: Recommended Actions on 2010 House Policies and Directives

Number	Title	Recommended Action and Rationale
D-100.976	Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance	Retain. Still relevant.
D-100.997	Use of Antimicrobials in Consumer Products	Retain in part to read as follows and change to an H-policy: Our AMA will: (1) ~~encourage the Food and Drug Administration (FDA) to expedite their regulation of the use in consumer products of antimicrobials for which acquired resistance has been demonstrated;~~ ~~(2)~~ continue to monitor the impact ~~progress~~ of the ~~current~~ FDA evaluation and final guidance related to ~~of~~ the safety and effectiveness of antimicrobials for consumer use in over-the-counter (OTC) hand and body washes; and (~~3~~2) encourage continued research on the use of common antimicrobials as ingredients in consumer products and its impact on the major public health problem of antimicrobial resistance.
D-130.967	Helicopter Emergency Medical Services (HEMS) Medical Provider and Patient Safety	Retain in part to read as follows and change to an H-policy: Our AMA: (1) ~~will educate its members about~~ supports the Federal Aviation Administration's (FAA) Helicopter Air Ambulance Operations guidelines ~~Medical Service Operations and Safety Alert for Operators SAFO 06001~~ and its role as a critical component of Helicopter Emergency Medical Services in assuring the safety of patients and medical providers; and (2) advocates that its members contract with or implement a Helicopter Emergency Medical Service that is compliant with risk reduction systems/programs established in standards set forth ~~in~~ by the FAA ~~Federal Aviation Administration's Helicopter Medical Service Operations and Safety Alert for Operators~~.
D-140.961	The Decade of Pain Control and Research	Rescind. The AMA has more recent policy that disagrees with some of the underpinnings of this initiative. Policy D-450.956 Pain as the Fifth Vital Sign advocates for removal of pain as a vital sign from Joint Commission standards. More recent policies support pain control and research based on current scientific evidence.
D-245.994	Infant Mortality	Retain. Still relevant.
D-365.999	Prophylaxis for Medical Students Exposed to Bloodborne Pathogens	Rescind. Accomplished. Bloodborne pathogens and trainees also addressed in CME/CSAPH report 1-A-19 updated policy.

Number	Title	Recommended Action and Rationale
D-370.996	Xenotransplantation: Scientific Implications	Rescind. The Secretary's Advisory Committee on Xenotransplantation (SACX) was disbanded in 2006. Also addressed in H-370.972.
D-370.997	The Physician's Role in Organ Donation	Retain. Still relevant.
D-40.999	Medical Care for Persian Gulf War Veterans	Retain. Still relevant.
D-430.999	Preventing Assault and Rape Of Inmates By Custodial Staff	Retain and change to an H policy
D-460.976	Genomic and Molecular-based Personalized Health Care	Retain. Still relevant.
D-95.980	Opioid Treatment and Prescription Drug Monitoring Programs	Retain. Still relevant.
H-10.998	Impact-Resistant Lens	Retain. Still relevant.
H-100.959	Mandatory Electrophysiologic Testing for Patients Taking Vigabatrin (Sabril)	Rescind. Accomplished. On July 21, 2016, the REMS for vigabatrin were modified to be less prescriptive for prescribers.
H-100.963	Essential Medicines for the Developing World	Retain. Still relevant.
H-100.968	Improving the Quality of Geriatric Pharmacotherapy	Retain. Still relevant.
H-100.981	United States Pharmacopoeial Convention Meetings	Retain. Still relevant.
H-100.986	Ethical Concerns and Development of New Medications	Retain. Still relevant.
H-100.995	Support of American Drug Industry	Retain. Still relevant.
H-100.997	Drugs of Choice	Retain. Still relevant.
H-115.980	Distinctive Labeling of Vials and Ampules, Prefilled Syringes, Ophthalmic Solutions and Related Liquid Medications	Retain. Still relevant.
H-115.996	Generic Labeling for Drugs Crossing International Borders	Retain. Still relevant.
H-120.958	Supporting Safe Medical Products as a Priority Public Health Initiative	Retain in part to read as follows: Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation ~~i~~on the ~~National Patient Safety Foundation's efforts to advance the science of safety in the medication use process and likewise work with the~~ National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and

Number	Title	Recommended Action and Rationale
		awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national ~~machine-readable~~ coding system for prescription medicine packaging in an effort to improve patient safety; and (5) ~~participate in and report on the work of the Healthy People 2010 initiative in the area of safe medical products especially as it relates to existing AMA policy; and~~ (6) seek opportunities to work collaboratively with other stakeholders ~~within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS)~~ to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.
H-120.997	Child-Protective Containers for Medications	Retain. Still relevant.
H-130.949	Organized Medicine's Role in the National Response to Terrorism	Retain. Still relevant.
H-130.971	Emerging Toxic Challenge	Retain with a change in title: ~~Emerging Toxic Challenge~~ Poison Information Programs
H-130.998	Special Amateur Radio Bands for Medical Emergencies	Retain. Still relevant.
H-135.935	OSHA Standards for Lead	Retain. 50 ug/m^3 is still the permissible exposure limit.
H-135.968	Support for the Improvement of the Health Environment in Developing Countries	Retain. Still relevant.
H-135.969	Environmental Health Programs	Retain. Still relevant.
H-135.971	Low-Level Radioactive Waste Disposal Facility	Retain. Still relevant.
H-135.972	Environmental Preservation	Retain. Still relevant.
H-135.976	Electromagnetic Pulse (EMP) and its Effects	Retain. Still relevant.
H-135.993	Transportation and Storage of Hazardous Materials	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
H-135.996	Pollution Control and Environmental Health	Retain. Still relevant.
H-15.970	Trucks and Highway Safety	Retain in part to read as follows: The AMA (1) reaffirms its recommendation in Report I (I-82) to establish a reduction in highway injuries and deaths as a national goal; special attention should be given to this goal by the governmental, business, engineering, legal, and medical sectors; (2) urges vehicle manufacturers to improve the safety of trucks and truck cabs; (3) ~~encourages adoption of~~ supports the strict standards on drug and alcohol use set in the Omnibus Transportation Employee Testing Act, requiring DOT agencies to implement drug and alcohol testing of safety-sensitive transportation employees ~~similar to those for locomotive engineers, for truck drivers~~; and (4) encourages regulators and truck fleet supervisors to give greater attention to drivers' performances and crash records, and to remove drivers with poor records from the highway.
H-15.972	Licensing People to Drive	Retain in part to read as follows: ~~It is the policy of~~ ~~t~~The AMA encourages (1) ~~to encourage~~ research into the many components ~~and activities~~ of ~~the~~ driving ~~task~~ and into the development of more accurate testing devices; (2) ~~that~~ physicians to continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving; (3) ~~that the~~ physicians to ~~attempt to~~ give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and (4) ~~that the~~ physicians, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test. Citation: (BOT Rep. L, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)
H-15.982	Mandatory Seat Belt Utilization Laws	Retain. Still relevant.
H-15.995	Medical Advisory Boards in Driver Licensing	Retain. Still relevant.
H-150.936	Support for Uniform, Evidence-Based Nutritional Rating System	Retain. Still relevant.
H-150.938	Healthy Food Options for Shift Workers	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
H-150.939	Accurate Reporting of Fats on Nutritional Labels	Retain. Still relevant.
H-150.940	Update on the Food and Drug Administration's Efforts to Improve Food Safety	Retain. Still relevant.
H-170.993	Health Education	Retain. Still relevant.
H-170.996	Establishing Active Liaison with Schools and Colleges	Retain. Still relevant.
H-20.918	Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission	Retain. Still relevant.
H-20.920	HIV Testing	Retain in part to read as follows: …(4) HIV Testing Procedures a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis; b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy; c~~) Appropriate medical organizations should establish a standard that a second blood sample be taken and tested on all persons found to be seropositive or indeterminate for HIV antibodies on the first blood sample. This practice is also advised for any unexpected negative result;~~ ~~d)~~ Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection; d~~e~~) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results ~~Western blots or other confirmatory procedures~~; e~~f~~) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved. (5) Routine HIV Testing a) Routine HIV testing should include appropriate~~ly modified~~ informed consent and ~~modified~~ pre-test and post-test counseling procedures;

Number	Title	Recommended Action and Rationale
		~~b) Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include (i) the likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk; (ii) the prevalence of HIV in patients undergoing invasive procedures; (iii) the costs, liabilities and benefits; and (iv) alternative methods of patient care and staff protection available to the patient;~~ b~~e~~) State medical associations should ~~review and seek modification of~~ work to create state laws that ~~restrict the ability of~~ encourage hospitals and other medical facilities to initiate routine HIV testing programs; ~~(d) Encourages a review of the evidence for routine HIV testing by the US Preventive Services Task Force;~~ and d~~e~~) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers. (6) Voluntary HIV Testing a) Voluntary HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Voluntary HIV testing should be regularly provided for ~~the following types of~~ individuals who give an informed consent~~: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures~~; ~~b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If voluntary HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.~~ (7) Mandatory HIV Testing a) Our AMA opposes mandatory HIV testing of the general population;

Number	Title	Recommended Action and Rationale
		b) Mandatory testing for HIV infection is recommended for (i) all entrants into federal and state prisons; (ii) military personnel; (iii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception; c) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances. (8) HIV Test Counseling a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present; b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment; c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection. (9) HIV Testing of Health Care Workers a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations; b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV; c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges; d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV ~~that pose a significant risk of transmission of HIV infection should voluntarily~~

Number	Title	Recommended Action and Rationale
		~~determine their serostatus at intervals appropriate to risk and/or act as if their serostatus were positive. The periodicity will vary according to locale and circumstances of the individual and the judgment should be made at the local level. Health care workers who test negative for HIV should voluntarily redetermine their HIV serostatus at an appropriate period of time after any significant occupational or personal exposure to HIV. Follow-up tests should occur after a time interval exceeding the length of the "antibody window~~. (10) Counseling and Testing of Pregnant Women for HIV Our AMA supports the position that there should be universal HIV testing of all pregnant women, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent. (11) HIV Home Test Kits a) O~~ur AMA opposes Food and Drug Administration approval of HIV home test kits. However, o~~ur AMA does not oppose ~~approval of~~ HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease; b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies; ~~c) A national study of HIV home collection test kit users should be performed to evaluate their experience with telephone counseling;~~ ~~d) A national interagency task force should be established, consisting of members from government agencies and the medical and public health communities, to monitor the marketing and use of HIV home collection test kits.~~ (12) College Students Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.
H-215.972	Use of Wireless Radio-Frequency Devices in Hospitals	Retain. Still relevant.
H-215.983	Distribution of Drug Samples in the in-Hospital Setting	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
H-220.962	Selection of Medical Staff Officers and Clinical Department Chairs	Retain. Still relevant.
H-220.998	Education and Control of Therapeutic and Diagnostic Drug Usage	Retain. Still relevant.
H-245.988	Cardiopulmonary Resuscitation Training for Expectant and New Parents	Retain. Still relevant.
H-245.989	Adequate Funding of the WIC Program	Retain. Still relevant.
H-245.990	Infant Walkers	Retain. Still relevant.
H-245.992	Perinatal and Infant Mortality Reviews	Retain. Still relevant.
H-245.999	Centralized Community and Regionalized Perinatal Intensive Care	Retain. Still relevant.
H-25.992	Senior Suicide	Retain. Still relevant.
H-25.993	Senior Care	Retain. Still relevant.
H-260.963	Standardization of Testosterone Assays	Retain. Still relevant.
H-260.982	Regulation of Clinical Laboratories	Retain. Still relevant.
H-260.983	Repeal of Assignment of Physician-Office Laboratory Services	Retain. Still relevant.
H-260.984	Quality of Cytotechnology	Retain. Still relevant.
H-275.964	Impaired Physicians Practice Act	Rescind. Addressed in Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990.
H-280.961	Use of Restraints for Patients in Nursing Homes	Retain. Still relevant.
H-30.972	Alcohol Abuse and the War on Drugs	Retain in part to read as follows with change in title: Harmful Alcohol Use ~~Abuse~~ and Concomitant Substance Misuse ~~the War on Drugs~~ Our AMA (1) supports documenting the strong correlation between harmful alcohol ~~ab~~use and other substance ~~ab~~misuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between harmful alcohol ~~ab~~use and other substance ~~ab~~misuse and recommendations to decrease the immense number of health, safety, and social problems associated with harmful alcohol ~~ab~~use.

Number	Title	Recommended Action and Rationale
H-30.998	Recommendations for AMA Involvement in Alcoholism Activities	Retain in part to read as follows with change in title: Recommendations for AMA Involvement in ~~Alcoholism~~ Activities Related to Alcohol Use Disorder To further emphasize the seriousness of alcohol use disorder ~~alcoholism~~ and the importance of the physician's role in prevention and treatment of this disease, our AMA: (1) encourages relevant medical specialty societies to inform their membership about opportunities for treatment and early intervention, especially among women with alcohol use disorder ~~alcoholics~~ and children of those with alcohol use disorder ~~alcoholics;~~ (2) encourages the broadcasting industry and appropriate advertising agencies to formulate a sustained public service campaign on the medical and social hazards of excessive alcohol use; (3) reaffirms that effective and comprehensive treatment for ~~alcoholic~~ persons with alcohol use disorder requires the involvement of a physician; and (4) urges that quality of treatment not be sacrificed to cost considerations.
H-345.998	Reaffirmation of Position Regarding Diagnosis and Treatment of Mental Disorder	Retain. Still relevant.
H-35.990	Non-Physician Measurement of Body Functions	Retain. Still relevant.
H-350.966	Health Initiatives on Asian-Americans and Pacific Islanders	Retain. Still relevant.
H-365.987	Revising "Guides to the Evaluation of Permanent Impairment"	Retain. The 6th Edition of the Guidelines was released in 2008, after not being updated for 18 years. It is safe to assume there will be a need for future updated versions.
H-365.988	Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies	Retain. Still relevant.
H-365.998	Confidentiality of Occupational Medical Records	Retain. Still relevant.
H-370.972	Xenotransplantation: Scientific Implications	Retain. Still relevant.
H-370.973	Methadone Maintenance and Transplantation	Retain. Still relevant.
H-370.985	Insurance Coverage for Immunosuppression in Transplant Patients	Retain. Still relevant.
H-410.954	Support an Independent Clinical Practice Guideline Development Process	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
H-410.964	Education Programs for Performance Improvement Activities in Physician Offices	Retain. Still relevant.
H-410.974	Development of Practice Parameters by Non-Physician Organizations	Retain. Still relevant.
H-410.995	Participation in the Development of Practice Guidelines by Individuals Experienced in the Care of Minority and Indigent Patients	Retain. Still relevant.
H-420.956	Stillbirth Awareness	Retain. Still relevant.
H-420.968	Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women	Retain. Still relevant.
H-420.970	Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy	Retain. Still relevant.
H-420.973	Adoption	Retain. Still relevant.
H-420.995	Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns	Retain. Still relevant.
H-420.998	Obstetrical Delivery in the Home or Outpatient Facility	Retain. Still relevant.
H-425.980	Screening and Early Detection of Prostate Cancer	Because of the possibility of age change for testing and the next review for this policy in 10 years, the recommendation is to remove the portion referring to specific ages and for the policy to remain broadly relevant. Therefore, retain in part to read as follows: Screening and Early Detection of Prostate Cancer H-425.980 Our AMA believes that: (1) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making. (2) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination. ~~(3) Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include: (a) Men 40 years of age or older of African American descent; (b) Men 40 years of age or older with an~~

Number	Title	Recommended Action and Rationale
		~~affected first-degree relative; and (c) Men 50 years of age or older.~~
H-425.989	Encouraging Health Activism by Physicians	Retain. Still relevant.
H-425.998	Pharmacist in Hypertension Screening	Retain. Still relevant.
H-440.907	Hand Washing	Retain. Still relevant.
H-440.952	Routine Immunization Against Measles in Children	Retain. Still relevant.
H-440.955	Federal Funding to Eliminate Tuberculosis as a Public Health Problem	Retain. Still relevant.
H-440.956	Measles Vaccine	Retain. Still relevant.
H-440.960	The IOM Report (The Future of Public Health) and Public Health	Retain in part to read as follows with change in title: ~~The IOM Report (The Future of Public Health)~~ Organized Medicine and Public Health Collaboration H-440.960 Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals and those representing physicians in private practice or academic medicine; (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; (4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program; (5) encourages public health agencies~~, as the IOM report suggests,~~ to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities ~~such as those mentioned in the "Model Standards"~~; (6) ~~encourages physicians and others interested in public health programs to apply the messages and injunctions of the IOM report as these fit their own situations and communities;~~ and ~~(7)~~ encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics.

Number	Title	Recommended Action and Rationale
H-440.964	Elimination of Tuberculosis	Retain. Still relevant.
H-440.979	Control of Sexually Transmitted Infections	Retain. Still relevant.
H-440.988	Pneumococcal, Influenza and Hepatitis-B Vaccines	Rescind. The AMA has more recent policy addressing each of these vaccines and vaccine financing.
H-440.992	National Immunization Program	Retain. Still relevant.
H-440.993	Smallpox Vaccination Policy	Retain. Still relevant.
H-440.995	Complete and Prompt Reporting of Measles (Rubeola)	Retain. Still relevant.
H-440.996	Sexually Transmitted Disease Control	Retain in part to read as follows with change in title: Sexually Transmitted Infection ~~Disease~~ Control H-440.996 Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control sexually transmitted infection ~~disease~~; (2) urges physicians to take all appropriate measures to reverse the rise in sexually transmitted infection ~~disease~~ and bring it under control; (3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of sexually transmitted infection ~~disease~~, with particular emphasis on control of gonorrhea; and (4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for sexually transmitted infection ~~disease~~ in minors legally without the necessity of obtaining parental consent.
H-445.994	Corporate Visitation Program	Retain. Still relevant.
H-450.949	Update on Patient Safety	Retain. Still relevant.
H-450.970	Quality Management Principles	Retain. Still relevant.
H-450.979	Impact of Quality of Care Analysis	Retain. Still relevant.
H-455.983	Radiographic Contrast Media	Retain. Still relevant.
H-455.984	Health Effects of Radon Exposure	Retain. Still relevant.
H-455.996	Nuclear Regulatory Commission Licensure Requirements for Physicians	Retain. Still relevant.
H-455.997	Human Use of Byproduct Material	Rescind. No longer relevant.
H-460.916	Protection of Human Subjects in Research	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
H-460.921	Support for Institutional Review Boards	Retain. Still relevant.
H-460.926	Funding of Biomedical, Translational, and Clinical Research	Retain. Still relevant.
H-460.933	Clinical Research and the AMA	Retain. Still relevant.
H-460.956	The Need for Increased Research and Development in Nuclear Fusion to Reduce Environmental Pollution	Retain. Still relevant.
H-460.959	Health Services Research Training	Retain. Still relevant.
H-460.962	National Human Genome Research Institute	Retain. Still relevant.
H-460.964	Use of Animals in Research	Retain. Still relevant.
H-460.986	Financial Protection for Clinical Research	Rescind. Addressed in H-460.926, H-460.943, and H-460.998.
H-460.996	Basic Research	Retain. Still relevant.
H-480.952	Prevent Mistaken Medical Tubing Connections	Retain. Still relevant.
H-480.960	Preventing Needlestick Injuries in Health Care Settings	Retain. Still relevant.
H-480.973	Unconventional Medical Care in the United States	Retain in part to read as follows: Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) ~~Office of Alternative Medicine~~ of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the ~~National Institutes of Health's National Center for Complementary and Alternative Medicine's~~ classification system of alternative medicine set forth by the NCCIH at the NIH, "Major Domains of Complementary and Alternative Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine.
H-480.986	Registry of Implantable Devices	Retain. Still relevant.
H-490.908	Tobacco-Free School Environment	Retain. Still relevant.
H-50.985	Nationwide Reporting of Elevated Blood Lead Levels	Retain. Still relevant.
H-50.996	Blood for Medical Use	Retain. Still relevant.
H-515.988	Repeal of Religious Exemptions in Child Abuse and Medical Practice Statutes	Retain. Still relevant.
H-520.992	Chemical and Biologic Weapons	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
H-55.986	Home Chemotherapy and Antibiotic Infusions	Retain. Still relevant.
H-55.998	Staging of Cancer	Retain. Still relevant
H-55.999	Symptomatic and Supportive Care for Patients with Cancer	Retain. Still relevant.
H-60.952	AMA Support for the United Nations Convention on The Rights of the Child	Retain. Still relevant.
H-60.998	Ipecac as Household Poison Emetic	Rescind. New evidence shows syrup of ipecac is no longer recommended for treating poisoning and that it can be misused.
H-75.986	Drug Interactions Between Oral Contraceptives and Antibiotics	Retain. Still relevant.
H-80.994	Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System	Retain. Still relevant.
H-85.981	Improving the Accuracy of Death Certificates	Retain. Still relevant.
H-90.998	Excluding Handicapped from Contact Sports	Retain. Still relevant.
H-90.999	Access to Public Buildings for Handicapped Persons	Retain. Still relevant.
H-95.957	Methadone Maintenance in Private Practice	Retain. Still relevant.
H-95.967	Drug Abuse	Retain in part with a change in title to read as follows: Harmful Substance ~~Drug Abuse~~ Use Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce harmful substance ~~drug ab~~use and that said commitment encourage involvement in at least one of the following roles: (1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about harmful substance ~~drug ab~~use; (2) join or organize local groups dedicated to ~~drug abuse~~ the prevention of harmful substance use; (3) talk to youth groups about brain damage and other deleterious effects of harmful substance ~~drug ab~~use; and (4) educate and support legislators, office holders and local leaders ~~toward~~ about ways to end~~ing~~ harmful substance ~~drug ab~~use ~~crisis~~ and providing adequate treatment to patients with substance use disorder.

Number	Title	Recommended Action and Rationale
H-95.973	Increased Funding for Drug Treatment	Retain in part to read as follows: Increased Funding for Substance Use Disorder ~~Drug~~ Treatment Our AMA (1) urges Congress to substantially increase its funding for substance use disorder ~~drug~~ treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder ~~drug~~ treatment system.
H-95.977	Medical Direction of Methadone Treatment	Retain. Still relevant.
H-95.991	Referral of Patients to Chemical Dependency Programs	Retain in part to read as follows: Referral of Patients to Substance Use Disorder Treatment Programs ~~Chemical Dependency~~ Our AMA urges its members to acquaint themselves with the various substance use disorder treatment ~~chemical dependency~~ programs available for the medical treatment of alcohol and drug use and, where appropriate, to refer their patients to them promptly.