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REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1, November 2020

Subject: International Medical Graduates Section Five-Year Review

Presented by: Shannon Pryor, MD, Chair

Referred to: Reference Committee F

The Council analyzed information from a letter of application submitted in June 2019 from the International Medical Graduates Section (IMGS) for renewal of delineated section status and representation in the AMA House of Delegates (HOD). The letter focuses on activities beginning in June 2014.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The IMGS is the only group within the AMA that represents and promotes the interests of physicians who have graduated from medical schools outside the United States or Canada. The IMGS serves its constituents by bringing critical IMG professional issues to the forefront of organized medicine and by providing targeted educational and policy resources.

The mission statement of the IMGS includes the following objectives:

- Represent the views of IMGs in the AMA HOD
- Increase the impact of IMG viewpoints in organized medicine
- Promote IMG participation and visibility at all levels of organized medicine
- Establish two-way communications between grassroots IMGs and organized medicine

During the last five years the following priority issues have been the focus of the IMGS:

- Licensure Parity – 34 states have separate and unequal graduate medical education (GME) requirements for U.S. medical graduates and IMGs and there are significant variations in the GME requirements between states. The IMGS continuously collaborates with staff of the AMA Advocacy Unit to work toward uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in

the years of GME required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. The IMGS worked with the Advocacy Resource Center to develop a model resolution for states to achieve licensure equality between U.S. medical graduates and IMGs. Several states have adopted this policy.

- Immigration – The IMGS works with the AMA Washington D.C. office to stay abreast of the immigration issues that affect the J-1 Visa Waiver and Conrad 30 Waiver programs for IMGs practicing in underserved areas. Congressional bills that allow for expansion of the Conrad 30 program beyond the assigned 30 slots are monitored on a regular basis. Reauthorizations of the Conrad 30 bill have resulted in more than 16,000 physicians practicing in underserved areas. Additionally, the IMGS has authored or contributed to a total of 17 resolutions and reports that have been adopted by the AMA HOD regarding the Conrad 30 and J-1 Visa Waiver programs.

- Graduate Medical Education Expansion – Thousands of qualified IMGs (many who are U.S. citizens or permanent residents) have been unable to enter the physician workforce due to the number of GME positions being capped by Congress in 1994. Simultaneously, the physician workforce shortage continues to grow. The section's legislative priority has been to call for an increase in the number of GME positions to help alleviate the physician workforce shortage and increase access to care for patients.

- Discrimination – Discriminatory issues have been addressed by the IMGS through resolutions submitted to the HOD, educational sessions, open forums, webinars, employment contract guidelines and the filing of amicus briefs. Some professional issues addressed include the Bachelor of Medicine and Bachelor of Surgery (MBBS) degree equivalent; licensure disparity; disparities in the residency selection process; and visa issues related to delays, denials, caps and green card backlogs. The IMGS has worked with AMA staff to communicate with the U.S. Citizenship Immigration Services and U.S. congresspeople regarding these issues.

CLRPD assessment: The IMGS provides the only formal structure for physicians who graduated from medical schools outside the United States and Canada to participate directly in the deliberations of the HOD and the activities of the AMA. The section's areas of focus are of specific concern to IMGs, and the IMGS works to ensure that the unique viewpoints of IMGs are represented in organized medicine.

Criterion 2: Consistency – Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The IMGS has worked to connect its activities to the AMA's strategic goals. Some efforts have included the launch of a digital community that has hosted approximately 15 online discussions on issues connected to the AMA's strategic direction, such as improving health outcomes, solutions to a healthier nation and health equity. More than 700 members signed up for the digital community in the first six months of its existence, and discussions have led to more than 25,000 pageviews and comments by physician members.

The IMGS also collaborated with the Improving Health Outcomes group on awareness campaigns that provide outreach and information to underserved areas on blood pressure and diabetes. In 2019, the IMGS collaborated with the Medical Student and Resident and Fellow Sections to participate in the AMA Research Symposium/Expo for the eighth consecutive year. During the

event, Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians who are awaiting residency showcase research for adjudication by expert physician panels.

The IMGS strives to equip physician leaders with the knowledge, skills, resources and opportunities to influence organized medicine. The Busharat Ahmad, MD Leadership Development Program has been available at each Annual and Interim Meeting since 2008 and aims to provide participants with skills to become more effective leaders. Several sessions qualified physicians for *AMA PRA Category 1 Credit™*.

In addition, members of the IMGS serve as AMA ambassadors to champion the value of AMA membership and publicize AMA work. IMGs also participate in the Members Move Medicine campaign, helping to demonstrate the value of the AMA and IMGS and carry the AMA message forward.

CLRPD Assessment: The IMGS has worked to align its goals and activities with the strategic direction of the AMA. The section collaborates regularly with other AMA groups and units to develop and participate in programs that support the AMA's strategic goals while avoiding duplication of effort and resources.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

Nearly 6,000 IMGS members participate in some aspect of the business of the IMGS by attending meetings; participating in webinars, digital communities, committees, elections and/or online reference committees; responding to surveys; and/or participating at ethnic society meetings and exhibits.

The IMGS provides opportunities for its members to participate in the policymaking process biannually during annual and interim meetings of the HOD. An online member forum allows section members an opportunity to comment on and ratify reports and resolutions in advance of each meeting. The section has established deadlines for member input, which allows time for review by the Resolution and Policy Committee and IMGS members. Resolution guidelines and a checklist are provided to members via newsletters and the section's web page. All resolutions are vetted by section delegates, the Resolution and Policy Committee and the governing council (GC).

Elections for the IMGS GC are held annually and provide another mechanism for IMG members to become involved in section governance. Nominations are reviewed and scored by the IMGS nominating committee, which is comprised of section members. This process results in a roster of candidates for elections. The IMGS GC directs the section's agenda, endorses section members for leadership positions within the AMA and other organizations, carries out the policies and actions adopted by the IMGS, and works with AMA leaders to ensure alignment with the AMA strategic plan.

CLRPD Assessment: The IMGS provides a variety of opportunities for its members to participate in the activities of the section and the AMA policymaking process. The GC is elected by and from the section's membership. The IMGS structure is consistent with the objectives of this section.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A

substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Members of the IMGS are graduates of medical schools outside the United States or Canada. IMGs who join the AMA automatically become members of the IMGS. Involvement in the IMGS GC, committees, meetings and events require that a physician be a current AMA member.

The IMGS membership increased from approximately 37,000 to 43,554 members from 2014 to 2019. IMGS members represent 17.4% of AMA membership and account for 24.9% of all physicians in the United States, according to CLRPD Report 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership." Per that same report, the potential membership of the IMGS, i.e., all IMGs in the United States, is 306,782.

CLRPD Assessment: The IMGS is comprised of members from an identifiable segment of AMA membership and the general physician population. This group represents more than 1,000 AMA members.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

The IMG Advisory Committee became a section in 1997. The IMGS has averaged approximately 77 attendees at each section meeting since 2015. IMGS meetings and events are promoted via section newsletters, AMA Morning Rounds, 75 ethnic society partners and 25 IMG state chair groups. An ECFMG membership category was created to include early career physicians seeking assistance and support from the IMGS. This membership category includes approximately 5,000 ECFMG-certified physicians awaiting residency. From 2015 to 2018, IMG Symposium meetings averaged approximately 65 attendees and yielded 12 new AMA members.

Since its inception, the IMGS has authored over 115 resolutions addressing a broad range of IMG issues. Since 2014, the section has introduced 17 resolutions to our AMA HOD. New policies adopted by the HOD resulted in letters from the AMA being written to legislators on the topics of expansion of GME positions through alternative funding and the green card backlog for immigrant physicians on H-1B Visas; the development of educational programs during annual and interim meetings on competency and aging physicians; the creation of resources to help IMGs participate in organized medicine; and IMGS collaboration with the Council on Medical Education to communicate with management of the National Residency Matching Program on the issue of bias in the Electronic Residency Application Service.

Additionally, the IMGS has collaborated or will collaborate with other AMA units on HOD reports on topics including competency and aging physicians, physician burnout and wellness, legalization of the Deferred Action for Legal Childhood Arrival (DALCA), and the grandfathering of qualified applicants practicing in U.S. institutions with restricted medical licensure.

CLRPD Assessment: The IMGS has a history of more than 20 years with the AMA and continues to seek out opportunities to grow membership and engagement. The AMA HOD benefits from the distinct voice of the section; activities of the IMGS have led to the creation of policy and AMA activities addressing issues of relevance to IMGs.

Criterion 6: Accessibility – Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

The IMGS addresses issues that affect IMGs and creates opportunities for its members to engage in the policymaking process. According to CLRPD Report 1-A-19, IMGS make up 17.4% of AMA members and 22.9% of all physicians and medical students yet comprise only 6.7% of delegates and 9.2% of alternate delegates, demonstrating a significant level of underrepresentation in the AMA's policymaking body.

Section members have the opportunity to submit resolutions, as well as participate on committees and an online member forum. All resolutions are vetted by section delegates, the Resolution and Policy Committee and the GC. The section's Resolution and Policy Committee meets via teleconference biannually to discuss policymaking ideas that have been submitted, and authors of resolutions are invited to participate in each teleconference. IMGS members may also voice their opinions on policy initiatives during business meetings, reference committee hearings and IMGS caucuses. The online forum allows for both commenting on and ratification of resolutions, and has generated significant activity, averaging over 1,000 comments and approvals per year from 2015-2018 (a new process and subsequent delayed promotion hampered participation in 2019). The section makes resolution guidelines and a checklist available to members via newsletters and their web page. The IMGS also provides an opportunity for other sections and councils to provide input on resolutions being considered for annual and interim meetings, which are shared with the IMGS GC.

CLRPD Assessment: The IMGS provides opportunities for members of its constituency who are otherwise underrepresented to introduce issues of concern and participate in the HOD policymaking process.

CONCLUSION

The CLRPD has determined that the IMGS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section, allowing the continued focused representation of IMGS members in the HOD.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section through 2025 with the next review no later than the 2025 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2, November 2020

Subject: Organized Medical Staff Section Five-Year Review

Presented by: Shannon Pryor, MD, Chair

Referred to: Reference Committee F

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in June 2019 from the Organized Medical Staff Section (OMSS) for renewal of delineated section status and representation in the AMA House of Delegates (HOD). The letter focused on activities beginning in June 2014.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The OMSS addresses matters concerning hospital and health system medical staffs and, more generally, issues facing physicians, whether employed or in private practice, practicing within the hospital setting. Major concerns/issues addressed by the OMSS include, but are not limited to:

- Medical staff self-governance and the physician-hospital relationship;
- Medical staff functions such as credentialing, privileging, peer review, etc.;
- Physician protections such as due process rights, etc.;
- Quality improvement in the hospital setting;
- Hospital accreditation standards [Medicare's Conditions of Participation (CoPs) and deeming authorities] and other hospital-related regulatory and legislative matters;
- Hospital management models, such as co-management service line agreements and other joint management arrangements;
- Development of physician leaders in the hospital setting;
- Physician employment and contracting in the hospital setting; and
- Relationships between independent and employed members of the medical staff.

The OMSS empowers physicians affiliated with medical staffs to improve patient outcomes and physician experience, and to otherwise effect positive change in their practice environments. OMSS membership is open to AMA members selected by their hospital or health system medical

staffs to represent the interests and concerns of their medical staff peers at biannual OMSS meetings and to serve as liaisons between the OMSS and local medical staffs. As an advocate, the OMSS continues to play a critical role in helping medical staffs and their physicians remove roadblocks that impede patient care.

CLRPD Assessment: The OMSS is the sole component group that focuses on issues concerning hospital and health system medical staffs, and more generally, issues facing physicians practicing within the hospital setting. The section provides a direct and ongoing relationship between the AMA and this cohort of physicians.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

In 2017, the OMSS updated its publication, "AMA Physicians Guide to Medical Staff Organization Bylaws"—a reference manual for drafting or amending medical staff bylaws and improved understanding of emerging issues in health care that impact the medical staff. Additionally, the OMSS has produced the following resources:

- In 2017, the section delivered the presentation, "Managing Disruptive Behavior" to a group of more than 200 medical staff professionals at a conference of the National Association of Medical Staff Services, and worked with AMA Credentialing Services to develop a white paper on the topic for distribution at medical staff professional meetings and other relevant trade shows. In 2018, the OMSS created an online education module, "Addressing Disruptive Physician Behavior," which more than 400 registrants have completed to date.

- Since 2014, Medicare's CoPs have permitted unification of multiple medical staffs across a multi-hospital system. In 2017, the section observed that medical staffs were not officially unifying, but rather were unifying some functions while leaving others separate. The OMSS coined the term "systematization" to describe this phenomenon and has educated medical staff leaders on this topic.

- The OMSS conducted a comprehensive review of AMA policy on medical staff topics that led to the adoption of new policy, H-225.942, "Physician and Medical Staff Member Bill of Rights," which outlines the responsibilities and rights of both the medical staff organization and its individual members, and explicitly stated for the first time in AMA policy why medical staffs should be self-governing.

- A physician's surrender of privileges during an investigation has always been reportable to the National Practitioner Data Base (NPDB), even when the investigation ultimately clears the physician of any wrongdoing. However, 2016 revisions to The NPDB Guidebook prompted hospitals and other reporting entities to adopt a broader definition of "investigation," which interprets any leave of absence as a "surrender of privileges." OMSS addressed this alarming change by developing protective model medical staff bylaws language and a whitepaper to educate physicians on processes they should follow when taking a leave of absence or surrendering privileges.

Medical staff leaders, other physician members of the medical staff, hospital/health system administrators, health care law attorneys, medical staff professionals, state/specialty medical society leadership and staff, and other stakeholders look to the OMSS for guidance on the section's major concerns and other issues. Examples of OMSS collaborative efforts include the following:

- OMSS works closely with the National Association of Medical Staffing Services (NAMSS) on credentialing and privileging issues to ensure physician and resident interests are protected and the processes become as streamlined as possible.

- The section is working closely with the American Board of Medical Specialties (ABMS) as it begins implementation of a study of recommendations to revamp the Maintenance of Certification (now called Continuing Board Certification) process.

- Other Federation organizations, such as the American College of Surgeons regularly seek the section's advice on issues impacting upon OMSS members and their colleagues.

OMSS work continues to be in alignment with the AMA's three strategic arcs, for example:

- Input from OMSS medical staff representatives assist in guiding the AMA's work in the management of chronic diseases.

- The medical staffs and individual medical staff members are on the front line of care delivery to identify scientific and clinical expertise that future physicians must learn. Equally important, it is many of these physicians who will continue to mentor newly minted physicians.

- As educator and advocate to health system/hospital/medical group medical staffs and their physicians, the OMSS is focused on issues concerning physicians and health care systems. OMSS medical staff representatives report back to AMA on the activities that create roadblocks to the delivery of patient care and that detract from the joy of medical practice.

CLRPD Assessment: The OMSS serves its constituents by bringing unique professional issues to the forefront of organized medicine and by providing targeted educational and policymaking resources. Additionally, the section has selected areas of focus that align closely with the AMA's strategic direction and other AMA efforts/products and has sought opportunities for collaboration on cross-cutting issues and programs with other organizations.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

Prior to 2016, membership in the OMSS was reserved for physicians who had been officially selected to represent their medical staffs at OMSS business meetings. While supportive of this representative model, OMSS was concerned that it might be impairing the section's ability to engage physicians by limiting interaction with the AMA to a maximum of just one physician per medical staff. In 2016, OMSS decoupled "membership" in the section from voting rights at OMSS business meetings, expanding eligibility from physicians officially representing their medical staffs to all physicians who belong to a medical staff. However, voting and other rights (e.g., introducing business, making motions, serving in elected positions) remain limited to certified OMSS representatives.

In 2018, OMSS launched a comprehensive recertification process in which OMSS representatives were required to reconfirm their continuing status as the representative of the medical staff on file. This process resulted in the de-certification of a substantial number of representatives, most of whom had retired or who simply failed to respond to multiple email and phone inquiries from section leadership and staff. While the recertification effort reduced the number of OMSS

representatives to 137, the section has been diligent to rebuild its membership, growing the number of certified representatives by 17% (24 representatives) since 2018.

Section members are offered a wide range of opportunities to participate in OMSS activities. Although the Annual and Interim Meetings of the HOD are the most obvious of these opportunities, the section actively promotes the notion that one need not attend meetings to contribute to the work of OMSS and provides a variety of opportunities for between-meeting engagement, for example:

- OMSS committees: education (expanded in 2015 to include non-governing council members, policy (established in 2018), membership and engagement (established in 2018);
- Online member forum enables all representatives to contribute to the policymaking activities of the section, regardless of whether they can attend meetings;
- Quarterly conference calls update representatives on the work of the section;
- Surveys gauge representatives' interest in potential topics for future education programs;
- Surveys provide a voice to representatives in the section's strategic planning activities;
- Peer-to-peer outreach program for members who wish to contribute to recruitment efforts;
- Calls to action on vital legislative and regulatory issues (e.g., Joint Commission field reviews); and
- Weekly emails (sent to more than 800 subscribers) with relevant medical staff news.

In 2016 and 2017, the OMSS Governing Council (GC) conducted a comprehensive review of the section's work and developed a strategic framework to better focus the section's future efforts on patient outcomes and physician experience through education, advocacy, best practices and collaboration to ensure maximum impact.

CLRPD Assessment: The structure of the OMSS allows members to participate in the deliberations and pursue the objectives of the section, including opportunities for between-meeting engagement. The OMSS has decoupled membership in the section from voting rights at OMSS business meetings, which expanded membership eligibility to all physicians who belong to a medical staff. The OMSS GC developed a strategic framework to enhance the section's focus and impact of future efforts.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation, as each new section will be allocated only one delegate and one alternate delegate in the AMA HOD.

As of the 2019 Annual Meeting of the HOD, 161 OMSS representatives had been certified as official representatives of medical staffs. Assuming an average medical staff size of 150 physicians, 15% of practicing physicians are AMA members; therefore, OMSS conservatively estimates that approximately 3,600 AMA member physicians currently are directly represented in the OMSS through their staffs' OMSS representatives.

However, OMSS assumes (conservatively) that 60% of all practicing physicians (i.e., not including medical students, residents, or retired physicians) are members of at least one medical staff. Using data from CLRPD Report 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership," the section can deduce that the total potential representation in the OMSS is

approximately 63,000 (60% of 104,591 AMA practicing physician members who are appointed to at least one medical staff).

CLRPD Assessment: The OMSS conservatively estimates that 3,600 AMA member physicians are directly represented through their staffs' OMSS representatives, which exceeds the minimum threshold of 1,000 AMA members. Further, the total potential representation in the OMSS encompasses a significant number of AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians, who will be represented by this section. Both the segment and the AMA will benefit from an increased voice within the policymaking body.

Established in 1983, the OMSS submits an average of five to seven resolutions for consideration of the HOD at each meeting, over 90% of which are eventually adopted in some form. OMSS resolutions on pressing issues of medical staffs originate in one of two ways: 1) individual OMSS representatives who, through the experiences of the medical staffs they represent; or 2) OMSS representatives acting on behalf of their state-level OMSS groups whose medical societies are not well positioned to identify a problem or address an issue for the AMA policymaking process.

In addition to OMSS annual and interim meetings, the section hosts three "Medical Staff Update" webinars each year, which have averaged 46 attendees each since 2014. In total, 76% of currently certified OMSS representatives have attended at least one live event in the last three years. The impact of each OMSS meeting is felt far beyond the individuals in attendance, as OMSS representatives are expected to report back to the medical staffs they represent on the actions of the meeting and the ongoing activities of the section. The section facilitates this task by making available, soon after each meeting, a detailed meeting summary and PowerPoint presentation that representatives use to provide updates to their medical staffs. A 2018 census of OMSS representatives found that nearly 90% of respondents frequently or sometimes report on OMSS actions and activities during their medical staff meetings. Many representatives also report back to their state and specialty medical societies.

The OMSS traditionally has communicated with its members and other individuals interested in medical staff topics through a monthly email newsletter with approximately 800 subscribers. In 2017, OMSS launched a Facebook group, which currently has 210 members, to provide a platform for members to discuss relevant topics and stay connected on a personal level. Additionally, the section is actively exploring opportunities and platforms to engage members year-round in the policymaking process.

While the OMSS continues to explore other engagement options, the section has shifted its outreach focus to two key groups: 1) peers of existing OMSS members (i.e., peer-to-peer outreach program); and 2) individuals who have engaged with the AMA through a medical staff-related resource. This focus, and communication with these groups, yielded 20 new OMSS representatives in 2018.

CLRPD Assessment: The OMSS has a long history with the AMA and since its inception has taken numerous steps to align its structure with the policymaking activities of the AMA. The section has introduced or significantly contributed to many resolutions and reports that resulted in new policies; therefore, the HOD has benefited from the distinct voice of the OMSS.

Criterion 6: Accessibility - Provides opportunity for members of the constituency, who are otherwise under-represented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

Although supporting data are not available, it is reasonable to surmise that most members of the HOD are members of at least one medical staff. Many OMSS representatives (over 30%) serve as AMA delegates for their state or specialty medical societies. Thus, it appears that medical staff members and their concerns are well-represented in the HOD; however, it can be difficult to usher medical staff-related resolutions through the policymaking processes of state and specialty medical societies. This is true for multiple reasons, but perhaps primarily because many of these organizations lack the time, resources and expertise necessary to develop solutions to complex and nuanced medical staff problems.

The OMSS is the recognized center of expertise within the AMA for medical staff and hospital issues; therefore, the OMSS serves as an entry point to the HOD for most resolutions addressing these matters, even though such issues directly affect a large percentage of AMA delegates. In this sense, the OMSS provides an opportunity for "underrepresented" members to introduce issues of concern and to participate in the Association's policymaking process.

The section is a conduit for members to provide input on topics under consideration within the HOD. OMSS reviews resolutions and reports under consideration at each meeting and, in a democratic process led by the Governing Council, determines which items the section should take positions on and what those positions should be. The OMSS provides its members with opportunities to testify on behalf of the section at reference committee hearings and participate in briefing/strategy sessions before HOD reference committee hearings and during post-reference committee debriefings, both of which are open to all OMSS representatives and other AMA members interested in medical staff matters.

CLRPD Assessment: Medical staff physicians' concerns are significant and are frequently topics of discussion in reference committees and HOD sessions. The OMSS reviews, assesses and provides testimony on a wide variety of reports and resolutions related to issues facing physicians, whether employed or in private practice, who practice within the hospital setting. Consequently, having the perspective and expertise of the OMSS is important to the AMA when creating policy.

CONCLUSION

The CLRPD has determined that the OMSS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the OMSS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2025 with the next review no later than the 2025 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 3, November 2020

Subject: Establishment of the Private Practice Physicians Section

Presented by: Shannon Pryor, MD, Chair

Referred to: Reference Committee F

In April 2019, the Council on Long Range Planning and Development (CLRPD) received a Letter of Application from the Private Practice Physicians Congress (PPPC) requesting a change in status from a caucus to a section, the Private Practice Physicians Section (PPPS). AMA Bylaws on Sections (§7.00) define the mission of AMA sections and identify each section as fixed or delineated. This report presents CLRPD's evaluation of the proposal for the PPPS using the criteria identified by Policy G-615.001, "Establishment and Functions of Sections" in consideration of requests for establishing new sections or changing the status of member component groups.

APPLICATION OF CRITERIA

Following an initial review and discussion of the PPPC proposal for section status, the CLRPD posed additional questions to the leadership of the group for clarification of some of the information presented in its Letter of Application. This report presents each criterion followed by excerpts of the letter and PPPC leadership's response to CLRPD's request for additional information. The Council's assessment of how this information aligns with each criterion is included.

1. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

According to an AMA 2018 benchmark survey,[1] 2016 was the first year in which less than half of practicing physicians had an ownership stake in their practice and 2018 marked the first year in which there were fewer physician owners than employees. The findings underscore a trend of shifting ownership across physician practices. Over the last several years, the number of self-employed physicians has been on the decline. In 2018, nearly half (47.4%) of all patient care physicians were employed physicians--up 6% from 2012. In 2018, 45.9% of all patient care physicians were self-employed--down 7 points since 2012. Seven percent of physicians were independent contractors. In 2018, over half of physicians (54%) worked in physician-owned practices as an employee, owner or contractor—down from 60% in 2012. The share of physicians in solo practice dropped from 18.4% in 2012 to 14.8% in 2018. Of physicians who worked in physician-owned practices, 40% were small businesses with 10 or fewer physicians. Over the same period, the share of physicians working directly for a hospital or a practice at least partly owned by a hospital increased from 5.6% to 8%, with the share of physicians in hospital-owned practices increasing to 26.7%. While the AMA does not track specific data on private practice physicians per se, data from CLRPD Report 1-A-19[2] indicate that 7.7% of AMA members are solo practitioners and 1.4% of AMA members represent two-physician practices.

Established in 2008 as a caucus, the PPPC provides a dedicated forum to create awareness of private practice physician issues and strengthen the AMA's ability to represent this physician constituency. In many traditional private practice settings, physicians spend years, even decades, developing rapport with their patients and gaining an intimate knowledge of their medical history. Physicians make decisions based on their understanding of their patients' lifestyles and the effects those lifestyles have on patient health.

Over the past 12 years, through the forum and during meetings of the Congress, AMA members have identified and discussed private practice-related issues including: meeting patient expectations, remaining independent amidst rising costs of government reporting and changing reimbursement models, managing quality measures to maximize ability to meet payer requirements for reporting, managing inefficient EHR data entry without proper training and support, avoiding burnout and eliminating site of service payment differentials.

CLRPD Assessment: The proposed PPPS would be dedicated to advocacy on private practice physician policy issues, provide leadership development and educational opportunities for medical students and young physicians, and monitor trends and issues that affect private practice physicians.

2. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

As a caucus, the PPPC has very limited input into the business of the HOD, namely proposing and ushering through original resolutions regarding areas of concern to private practice physicians. Except for a room at each HOD meeting, the Congress has performed all of its activities without the advantages of AMA resources. In 2014, the PPPC received grants from the Physicians Foundation to assist its funding of educational programs and activities. Since 2008, PPPC has used a free Google Group Listserv for communications with its members.

Members of the AMA Integrated Physician Practices Section (IPPS) have delivered presentations during PPPC meetings; however, the perspectives of the two groups differ in that IPPS focuses on integration of care, which often takes place in large multispecialty systems; conversely, the PPPC focuses on the preservation of independent, private practices. Additionally, PPPC has engaged with the Medical Student Section, the Resident and Fellow Section, and the Young Physicians Section and found there is an interest among members of these sections to learn more about the lifestyle and interests of private practice physicians.

The goals of the PPPS include, but are not limited to, the following:

- Providing a forum for networking, mentoring, advocacy, educational activities and leadership development for private practice physicians, young physicians, residents and medical students.
- Contributing to AMA efforts to increase membership, participation, and leadership of private practice physicians in the AMA.
- Monitoring trends, identifying and addressing emerging professional issues affecting private practice physicians.
- Enhancing outreach, communications and working relationships between the AMA and organizational entities that are relevant to the activities of the section.
- Expanding AMA advocacy on private practice policy issues such as health system reform that enables private practices to remain economically and professionally viable.

CLRPD Assessment: The PPPS would generate projects relevant to private practice physicians and physicians in training who have an interest in private practice. Improving outreach and creating new opportunities for participation among private practice physicians may incentivize non-members of this demographic to become AMA members. Within the AMA, there are no component groups solely devoted to advocacy and education related to issues that are specific to the private practice of medicine.

3. Appropriateness - The structure of the group will be consistent with its objectives and activities.

The PPPS would provide a voice for physicians who are active members of the AMA in physician-owned private practices and a forum for physicians who are interested in or committed to the concept of physician owned and controlled practices to network. The section's Credentials Committee will review all applications for membership and determine whether an applicant's practice meets the criteria for membership. The PPPS would seek to be inclusive of AMA members; therefore, if an individual did not initially meet membership criteria, they could make a request for reconsideration by the governing council (GC).

As a section, the GC will submit nominations for elected positions of the GC, delegate and alternate delegate and allow for nominations and elections from the membership. Terms of service will be two years as proposed in the draft IOP. The GC and the delegates will meet prior to the AMA HOD meetings and at other times through the year.

The officers of the PPPS shall be the seven elected, voting members of the GC: chair, vice chair, secretary, delegate, alternate delegate, a member at-large from a practice of 1 to 8 physicians, and a member at-large from a practice of 9 to 50 physicians. Additionally, immediately upon completion of his or her term as chair, the immediate past chair shall serve, ex officio, as a voting member of the GC. All section members shall be eligible for election or appointment to the GC. If a GC member ceases to meet the eligibility requirements before the expiration of the term for which he or she was elected, the term of such member shall terminate, and the position declared vacant. The GC shall direct the programs and activities of the PPPS that are subject to approval by the BOT or HOD.

CLRPD Assessment: The structure of the proposed PPPS is conducive to sharing key concerns and identifying meaningful opportunities for private practice physicians, which supports the objectives of this group. In accordance with the AMA Bylaws, sections are required to have an elected GC from the voting members of the section and establish a business meeting that would be open to its members. The PPPC presently has an established online forum, which could create an avenue for a voting body to elect GC members. While the PPPC conducts a caucus at HOD meetings, as the Private Practice Physicians Section, the caucus will be restructured to mirror the assemblies used by the current delineated sections.

4. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation, as each new section will be allocated only one delegate and one alternate delegate in the AMA HOD.

According to CLRPD Report 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership," the combined number of physician members in solo (19,263) and small

physician practices (3,560) is approximately 12% of AMA physician members. According to the 2018 AMA benchmark survey, 47.1% of practicing physicians have an ownership stake in their practice--approximately 400,000 physicians. If AMA market share is considered to be 12% to 15%, then 48,000 to 60,000 physicians in private practice are AMA members and would be represented in the PPPS. While these numbers are estimates, the total is well above the 1,000 AMA member threshold.

CLRPD Assessment: Private practice physicians remain a substantial market segment for our AMA and this section would represent over 1,000 AMA members.

5. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians, who will be represented by this section. Both the segment and the AMA will benefit from an increased voice within the policymaking body.

The PPPC became more organized as its membership grew. Since 2013, the group's membership increased from around 50 to over 200 AMA members. Attendance at PPPC meetings ranges from 80 to 150 members--with 20 to 30 new members at each meeting. The PPPC listserv of approximately 200 participants connects the group's membership between and during meetings. Members are very well informed on the socioeconomic facets of medicine and PPPC leadership has remained stable.

The Congress convenes subcommittees focused on education, social media and member engagement and would institute a training program for members to assume leadership roles within the section. Section status would allow the group to develop and engage members in educational programs on private practice and leadership. Previously, the PPPC organized these types of programs for medical students and young physicians, which were well attended. Section status with the support of staff, who perform multiple tasks that enhance the work of sections, e.g., engaging in research, managing communications, promoting membership growth, preparing for meetings, and facilitating the development of educational activities on topics of interest to section members would provide a formalized structure with systematic and administrative processes to ensure stability of the section.

CLRPD Assessment: Since its inception, the Congress has taken steps to align its structure with the activities of the AMA. PPPC leadership has built a solid foundation for the group, which, at this stage, would benefit from a delegate's voice to address private practice issues in the HOD. As the number of private practice physicians in the country continues to decline, the AMA's policymaking process could be strengthened by ensuring that the perspectives of these physicians are represented.

6. Accessibility - Provides opportunity for members of the constituency, who are otherwise under-represented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

AMA Masterfile data reflect the number of physicians by practice size as opposed to the number of physicians who have an ownership stake in a practice; however, it may be assumed that solo and two-physician practices are physician owned. CLRPD Report 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership," indicates solo practice physicians represent 15.0% and 9.7% of AMA delegates and alternate delegates respectively. Physicians in two-physician practices represent 2.2% of AMA delegates and 2.2% of alternate delegates. Even with a considerable number of physicians in the HOD, many members of these groups have an

obligation to represent the priorities of their state or specialty delegations rather than issues specifically related to private practice.

Currently, the PPPC has few opportunities to provide input into the business of the HOD, namely proposing and ushering through original resolutions regarding specific areas of concern for private practice physicians. During HOD meetings, members of the Congress have developed private practice-related resolutions; however, often issues of specific concern to private practice physicians are not brought forward for discussion in the House. While many private practice physicians are active in the HOD through various delegations, the majority are from small medical practices and the AMA has neither an established community/cohort, nor institutional support to address unique issues and concerns of these physicians through the policymaking process of the HOD.

The PPPC has become recognized as a nexus for private practice physicians within the AMA. The Association would benefit from providing the PPPS with an opportunity for "underrepresented" members seeking to preserve the independent practice of medicine to introduce specific issues of concern and participate in the AMA policymaking process. As a section, the PPPS would develop a formalized policymaking process and the section would introduce resolutions, which could change the dynamic.

CLRPD Assessment: Accessibility relates to a group having an opportunity to engage in the policymaking process of the HOD with respect to their specific issues of concern. A group comprised of a large number of individuals is not necessarily guaranteed access to this process. Even with the number of private practice physicians in the HOD, many members of this group have an obligation to represent the priorities of their respective state or specialty delegations. Given the limited opportunity to present issues of concern specific to this group, the CLRPD believes it would be appropriate to afford private practice physicians with an opportunity for a focused voice on their issues of concern, which are listed on pages 2-3.

DISCUSSION

Following an initial review and discussion of the PPPC proposal for section status, the CLRPD posed additional questions to leaders of the caucus for clarification of some of the information presented in its Letter of Application for Section Status. Further, Council members engaged in numerous, extended deliberations regarding the PPPC's request and met with its leadership for discussion.

Private practice physicians often have a distinct set of experiences related to medical practice and patient care. Like other AMA member component groups, the PPPC convenes prior to HOD meetings, engages in coalition building, and provides opportunities for education and involvement. Initially, the Council was concerned that the same three physicians have been leading the Congress since its inception; however, the PPPC has thoughtfully developed a succession plan for leadership of the PPPS.

Accessibility is considered as part of the rationale for establishing sections within the Association. Policy G-615.002, "AMA Member Component Groups" states, "Delineated sections allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be underrepresented. These sections will often be based on demographics or mode of practice." The CLRPD recognizes the continued decline in the number of independent, private practice physicians and that physician practice ownership is now below 50% among all physicians. Granting the PPPC section status will provide the new section with a voice through a delegate who participates in HOD meetings. The CLRPD concurs that the PPPC meets all criteria;

therefore, the Council recommends that the status for this member component group be changed to delineated section.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association transition the Private Practice Physicians Congress to the Private Practice Physicians Section as a delineated section. (Directive to Take Action)

2. That our AMA develop bylaw language to recognize the Private Practice Physicians Section. (Directive to Take Action)

Fiscal Note: $325,345/year (staff salary and benefits, governing council travel and meetings, annual and interim meeting costs, other staff travel and administrative expenses). All new sections in the recent past (Women Physicians Section, Senior Physicians Section, Integrated Physician Practice Section) had staff assigned and other AMA-allocated resources as Advisory Committees to the Board of Trustees prior to attaining section status.

REFERENCES

[1] AMA. *Updated data on physician practice arrangements; Physician ownership drops below 50 %.* https://www.ama-assn.org/about/research/physician-practice-benchmark-survey

[2] CLRPD. *Demographic Characteristics of the House of Delegates and AMA Leadership. https://www.ama-assn.org/system/files/2019-08/a19-clrpd-report-1.pdf*

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, November 2020

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Diana E. Fite, MD, Chair

Referred to: Reference Committee F

This report by the committee at the November 2020 Special Meeting of the House of Delegates presents one recommendation. It also documents the compensation paid to Officers for the period July 1, 2019 thru June 30, 2020 and includes the 2019 calendar year IRS reported taxable value of benefits, perquisites, services, and in-kind payments for all Officers.

BACKGROUND

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

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

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

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

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

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

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

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

At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the Committee's recommendation of modest increases to the Governance Honorarium and Per Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal Representation, greater than eleven days, receives a per diem.

At A-18, based on comprehensive review of Board leadership compensation, the HOD approved the Committee's recommendation to increase the President, President-elect, Immediate Past-President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

At A-18 and A-19, the House approved the Committee's recommendation to provide a Health Insurance Stipend to President(s) who are under Medicare eligible age when the President(s) and his/her covered dependents, not Medicare eligible, lose the President's employer provided health insurance during his/her term as President. Should the President(s) become Medicare eligible while in office, he/she received an adjusted Stipend to provide insurance coverage to his/her dependents not Medicare eligible.

The Committee's I-19 report recommended and the HOD approved the Committee's recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding Presidents and Chair, by approximately 3% each effective July 1, 2020.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium and Per Diem for Representation including conference calls with assigned groups outside of the AMA or

assigned Internal Representation days above 11 when the total of all teleconference meetings during a calendar day equal 2 or more hours approved by the Board Chair. Detailed definitions are in the Appendix.

The summary covers July 1, 2019 to June 30, 2020

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Officer	$ -	0.5
Grayson W Armstrong, MD, MPH	Resident Officer	$ 65,000	40
Susan R Bailey, MD	President-Elect	$ 288,860	92
Willarda V Edwards, MD, MBA	Officer	$ 72,800	41
Lisa Bohman Egbert, MD	Vice Speaker, House of Delegates	$ 68,900	46.5
Jesse M Ehrenfeld, MD, MPH	Chair & Young Physician Officer	$ 280,280	86.5
Scott Ferguson, MD	Officer	$ 68,900	38
Sandra Adamson Fryhofer, MD	Officer	$ 78,000	43
Gerald E Harmon, MD	Officer	$ 85,800	58.5
Patrice A Harris, MD, MA	President	$ 290,160	187
William E Kobler, MD	Officer	$ 83,200	53
Russ Kridel, MD	Chair-Elect	$ 207,480	44.5
Ilse R Levin, DO, MPH & TM	Officer	$ -	0.5
Thomas J Madejski, MD	Officer	$ -	0.5
Barbara L McAneny, MD	Immediate Past President	$ 284,960	92.5
William A McDade, MD, PhD	Officer	$ 71,500	38.5
Mario E Motta, MD	Officer	$ 72,150	39
Bobby Mukkamala, MD	Secretary	$ 74,100	50
Blake Elizabeth Murphy	Medical Student Officer	$ -	2
Harris Pastides, PhD, MPH	Public Board Member Officer	$ -	0.5
Jack Resneck, Jr, MD	Immediate Past Chair	$ 108,550	72
Bruce A Scott, MD	Speaker, House of Delegates	$ 83,850	51.5
Sarah Mae Smith	Medical Student Officer	$ 91,650	58.5
Michael Suk, MD, JD, MPH, MBA	Officer	$ 72,150	35
Willie Underwood, III, MD, MSc, MPH	Officer	$ 71,500	39.5
Kevin W Williams, MSA	Public Board Member Officer	$ 65,000	25

President, President-Elect, Immediate Past President, and Chair
In 2019 – 2020, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 458 days on approved Assignment and Travel, or 114.5 days each on average.

Chair-Elect
This position received a Governance Honorarium of approximately 75% of the Governance Honorarium provided to the Chair.

All other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $65,000 paid in monthly installments. The remaining cash compensation is for Assignment and Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal Representation days above 11. These days were compensated at a per diem rate of $1,300.

Assignment and Travel Days
The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 777.5.

EXPENSES

Total expenses paid for period, July 1, 2019 – June 30, 2020, $744,035 compared to $882,074 for the previous period, representing a 15.7% decrease. This includes $3,320 in upgrades for Presidents' travel per the approved Presidential Upgrade Allowance of $2,500 per position per term.

BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS

Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expense items are provided to assist the Officers in performing their duties.

- AMA Standard laptop computer or iPad
- iPhone
- American Express card (for AMA business use)
- Combination fax/printer/scanner
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationary, business cards, and biographical data for official use

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $750 per year per Officer. This is reported as taxable income.

Travel expenses incurred by family members are not reimbursable, except for the family of the incoming President at the Annual Meeting of the HOD.

Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled $42,984 and $23,875 respectively for 2019. An additional $17,250 was paid to third parties for secretarial services during 2019.

FINDINGS

The Cash Compensation Summary, with the exception of 2019 calendar year taxable compensation, reflects the impact of the Coronavirus on the Officers in representing our AMA. Effective March 17, 2020 all travel ceased, and all in-person meetings were canceled or moved to a virtual format. Our AMA leadership quickly pivoted to continue representing the AMA, both

internally and externally, in a completely virtual environment. This pivot, while appearing seamless, required significant flexibility and behind-the-scenes planning of our Officers. As you know, both our Annual and Interim Meetings were suspended, and all Board meetings since March 17 have been virtual. This environment also necessitated changes in reporting for the term ended June 30, 2020 as evidenced by suspending the tracking of telephonic representation meetings since all meetings were and continue to be conducted virtually.

Based on the data reported it would appear that the President, President-Elect, Immediate Past-President and Chair-Elect had a lighter workload, which would be an incorrect conclusion. These individuals, while relieved of their travel burdens, worked tirelessly representing the AMA in podcasts, on Facebook, Zoom, Microsoft Teams and other media to advocate on behalf of physicians and patients. In addition, the Speaker and Vice Speaker have expended an extraordinary amount of effort to plan both the June and November Special Meetings.

This Committee commends and thanks our Officers for their representation of the AMA.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends that there be no changes to the Officers' compensation for the period beginning July 1, 2021 through June 30, 2022 and the remainder of the report filed. (Directive to Take Action)

Fiscal Note: None.

APPENDIX

POSITION	**GOVERNANCE HONORARIUM**
President	$290,160
Immediate Past President	$284,960
President-Elect	$284,960
Chair	$280,280
Chair-Elect	$207,480
Officers	$67,000

Definition of Governance Honorarium Effective July 1, 2017:

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

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

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,400 per day.

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

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $700.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(November 2020)

Introduced by: Women Physicians Section

Subject: Support for the Establishment of Medical-Legal Partnerships

Referred to: Reference Committee F

Whereas, Social determinants of health such as employment, housing, transportation, and literacy are known to effect patients' overall health status and health outcomes;[1] and

Whereas, Physicians and trainees are inadequately trained to effectively and respectfully screen patients for social determinants of health;[2] and

Whereas, Simply screening patients for social determinants of health without providing resources or treatment options is ineffective;[2] and

Whereas, Addressing social determinants of health cannot be done by the medical community in isolation, but will need changes in law and policy as well;[3] and

Whereas, The medical system is full of complicated policies and administrative barriers that can be difficult to overcome without knowledge in poverty law and administrative law;[4] and

Whereas, Medical-legal partnerships formally include lawyers on a care team to address legal issues that may lead to poor health outcomes and contribute to population health inequities;[5,6] and

Whereas, Medical-legal partnerships seek to address patients' needs regarding social determinants of health through providing healthcare, and social and legal support at the same location;[7] and

Whereas, The most common needs medical-legal partnerships address are: income, housing and utilities, education and employment, legal status, and personal and family stability;[7] and

Whereas, Providing legal assistance at the same location as healthcare facilitates patients' use of these services to remediate their lack of basic human needs such as food and shelter;[7] and

Whereas, Medical-legal partnerships exist across 48 states with 442 partnerships across 333 healthcare entities;[5] and

Whereas, Medical-legal partnerships provide education for medical professionals to better identify unmet needs in their patients and to begin addressing those needs;[8] and

Whereas; Medical-legal partnerships have been proven to improve health outcomes for patients including reducing hospital admissions for chronic health conditions, reducing stress and improving mental health, and increasing the use of preventive health services;[9] and

Whereas, Medical-legal partnerships have also been proven to increase patient compliance with treatment, including patients regularly taking prescribed medications;[10] and

Whereas, Medical-legal partnerships have demonstrated a cost-savings to health care organizations through assisting patients in gaining health insurance coverage and in end-of-life planning;[11] therefore be it

RESOLVED, That our American Medical Association encourage the widespread establishment of medical-legal partnerships to address unmet patient needs relating to social determinants of health. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/20

References:
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11. "Impact." *The Impact*, National Center for Medical-Legal Partnerships, medical-legalpartnership.org/impact/.

RELEVANT AMA POLICY

Legal Protection and Social Services for Commercially Sexually Exploited Youth D-60.969

Our AMA will work with state medical societies and specialty societies to: (1) where appropriate, advocate for legal protection and alternatives to incarceration for commercially sexually exploited youth as an alternative to prosecution for crimes related to their sexual or criminal exploitation; and (2) encourage the development of appropriate and comprehensive services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth.
Citation: (Res. 4, I-14)

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health

professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
Citation: (CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.
Citation: (Res. 8, I-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(November 2020)

Introduced by: Women Physicians Section

Subject: Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA

Referred to: Reference Committee F

Whereas, Our AMA has as important goals, the promotion of healthcare diversity, the improvement of public health, and retention and expansion of membership; and

Whereas, Healthcare diversity, and the health of the public is improved when healthcare providers reflect the diversity of our patients; and

Whereas, AMA membership retention, expansion and participation are promoted when members and prospective members perceive themselves to be welcomed, fully enfranchised, protected, promoted and supported by their association, free from discrimination, and equally eligible for leadership; and

Whereas, Diversity in healthcare providers is promoted when equal opportunities exist in employment and leadership within healthcare organizations and in other practice settings; and

Whereas, Our AMA is obliged both as a large employer and as a place of public accommodation to practice nondiscrimination with respect to employment or access on account of or on the basis of race, color, sex, national origin, age, religion, disability, veteran status, sexual orientation or other protected characteristics; and

Whereas, Our AMA as a nonprofit physician membership association has additional morally based obligations to lead by example and not to discriminate as an organization on the basis of age, race, color, creed, gender, gender expression, national origin, locus of medical education or postgraduate training, cultural ethnicity, sexual orientation, disability, marital status, or military status, in any of its activities or operations**;** and

Whereas, The Code of Medical Ethics states that physicians “shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law”; and

Whereas, While numerous policies have been enacted over the years by our AMA that address selected aspects of discrimination by various groups against various groups, these policies are not uniform and relatively difficult to locate; there are policy gaps and inconsistencies relating to the lack of an organized approach to addressing the problem of discrimination, making it difficult to access the applicable policy or policies when a benchmark is needed against which to measure a proposed action being considered by the organization; and

Whereas, While our AMA has a nondiscrimination policy with respect to physician membership (AMA Bylaws 1-4)[1], it has at present no overarching nondiscrimination policy as a threshold and a benchmark tool against which to measure the taking of actions other than membership decisions, to determine whether entering into new policies, procedures, sponsorships, endorsements, promotion, legislative or other forms of advocacy, contracts, or proposed partnerships with other organizations; and

Whereas, Without a distinct threshold for consideration of, or benchmark tool against which to measure proposed organizational actions or partnerships as to potential or actual discriminatory effect, it is difficult to determine whether pursuit of such actions or partnerships should be avoided, modified or abandoned so as to avoid discrimination against members with protected characteristics, contrary to law and organizational moral principles, and to avert any resultant contravention of AMA ethical principles by those individual physician members involved in taking the proposed actions or participating in the proposed partnerships; and

Whereas, Not all third parties who conduct business with or for our AMA, such as independent contractors, consultants or vendors, necessarily recognize or independently endorse an obligation to comply with all applicable laws, rules and regulations; and if they do not comply, they will, under federal regulations, subject our AMA to potentially significant liability and adverse publicity; yet third parties are not at present apparently even subject to the published conflict of interest policy of the AMA; and

Whereas, Mandated signatories to the conflict of interest policy (e.g. AMA leaders, key staff and candidates) must agree to abide by AMA Policy H-140.837, “Policy on Conduct at AMA Meetings and Events.” The current conflict of interest policy refers to anti-harassment (AMA Policy H-140.837), however, it does not seem to address other forms of discrimination on the basis of protected characteristics; and

Whereas, Our AMA has not adopted a business conduct standards policy making explicit an obligation that every individual working on AMA business, be they member, employee or contractor, must adhere to the highest ethical standards, and demonstrate integrity, professionalism and respect for others and the law, in their dealings with and for the AMA; and

Whereas, Our AMA has not widely communicated a comprehensive strategy or program designed to eliminate bias and enhance diversity and inclusion throughout the association, the medical profession, and our healthcare system; therefore be it

RESOLVED, That our American Medical Association adopt an overarching nondiscrimination policy on the basis of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities that applies to members, employees and patients (New HOD Policy); and be it further

RESOLVED, That our AMA demonstrate its commitment to complying with laws, rules or regulations against discrimination on the basis of protected characteristics (Directive to Take Action); and be it further

[1] Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

RESOLVED, That our AMA reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040, “Principles on Corporate Relationships,” in its overarching non-discrimination policy (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment”; (New HOD Policy) and be it further

RESOLVED, That our AMA study the feasibility and need for a comprehensive business conduct standards policy to be fully integrated with the conflict of interest policy, and report back to the AMA House of Delegates within 18 months (Directive to Take Action); and be it further

RESOLVED, That our AMA provide an update on its comprehensive diversity and inclusion strategy to the AMA House of Delegates within 24 months. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/30/20

RELEVANT AMA POLICY

References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment G-600.067
Our AMA will: (1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not; (2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; (3) present the preliminary study results to the Minority Affairs Section, the Women’s Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and (4) produce a report within 18 months with study results and recommendations.
Res. 009, A-19

Discrimination. B-1.4
Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. Res. 001, A-18

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. BOT Rep. 27, A-19

9.5.5 Gender Discrimination in Medicine
Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.
Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness in the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate gender bias in research and publication.
AMA Principles of Medical Ethics: II,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Organizations Which Discriminate H-65.988
The AMA (1) encourages holding educational or business meetings or social gatherings in facilities of organizations and clubs which do not refuse membership on the basis of gender, race or religion; and (2) encourages its constituent societies to follow a similar policy. Res. 62, A-87; Reaffirmed: CLRPD Rep. 3, I-97; Reaffirmed: CEJA Rep. 7, A-07; Reaffirmed: CEJA Rep. 04, A-17

Principles on Corporate Relationships G-630.040
The House of Delegates adopts the following revised principles on Corporate Relationships. The Board will review them annually and, if necessary, make recommendations for revisions to be presented to the House of Delegates.
(1) GUIDELINES FOR AMA CORPORATE RELATIONSHIPS. Principles to guide AMA's relationships with corporate America were adopted by our AMA House of Delegates at its December 1997 meeting and slightly modified at the June 1998 meeting. Subsequently, they have been edited to reflect the recommendations from the Task Force on Association/Corporate Relations, including among its members experts external to our AMA. Minor edits were also adopted in 2002. The following principles are based on the premise that in certain circumstances, our AMA should participate in corporate arrangements when guidelines are met, which can further our AMA's core strategic focus, retain AMA's independence, avoid conflicts of interest, and guard our professional values.
(2) OVERVIEW OF PRINCIPLES. The AMA's principles to guide corporate relationships have been organized into the following categories: General Principles that apply to most situations; Special Guidelines that deal with specific issues and concerns; Organizational Review that outlines the roles and responsibilities of the Board of Trustees, AMA Management and other staff units. These guidelines should be reviewed over time to assure their continued relevance to the policies and operations of our AMA and to our business environment. The principles should serve as a starting point for anyone reviewing or developing AMA's relationships with outside groups.
(3) GENERAL PRINCIPLES. Our AMA's vision and values statement and strategic focus should provide guidance for externally funded relationships. Relations that are not motivated by the association's mission threaten our AMA's ability to provide representation and leadership for the profession.
(a) Our AMA's vision and values and strategic focus ultimately must determine whether a proposed relationship is appropriate for our AMA. Our AMA should not have relationships with organizations or industries whose principles, policies or actions obviously conflict with our AMA's vision and values. For example, relationships with producers of products that harm the public health (e.g., tobacco) are not appropriate for our AMA. Our AMA will proactively choose its priorities for external relationships and collaborate in those that fulfill these priorities.
(b) The relationship must preserve or promote trust in our AMA and the medical profession. To be effective, medical professionalism requires the public's trust. Corporate relationships that could undermine the public's trust in our AMA or the profession are not acceptable. For example, no relationship should raise questions about the scientific content of our AMA's health information publications, AMA's advocacy on public health issues, or the truthfulness of its public statements.
(c) The relationship must maintain our AMA's objectivity with respect to health issues. Our AMA accepts funds or royalties from external organizations only if acceptance does not pose a conflict of interest and in no way impacts the objectivity of the association, its members, activities, programs, or employees. For example, exclusive relationships with manufacturers of health-related products marketed to the public could impair our AMA's objectivity in promoting the health of America. Our AMA's objectivity with respect to health issues should not be biased by external relationships.
(d) The activity must provide benefit to the public's health, patients' care, or physicians' practice. Public education campaigns and programs for AMA or Federation members are potentially of significant benefit. Corporate-supported programs that provide financial benefits to our AMA but no significant benefit to the public or direct professional benefits to AMA or Federation members are not acceptable. In the case of member benefits, external relations must not detract from AMA's professionalism.
(4) SPECIAL GUIDELINES. The following guidelines address a number of special situations where our AMA cannot utilize external funding. There are specific guidelines already in place regarding advertising in publications.
(a) Our AMA will provide health and medical information, but should not involve itself in the production, sale, or marketing to consumers of products that claim a health benefit. Marketing health-related products (e.g., pharmaceuticals, home health care products) undermines our AMA's objectivity and diminishes its role in representing healthcare values and educating the public about their health and healthcare.
(b) Activities should be funded from multiple sources whenever possible. Activities funded from a single external source are at greater risk for inappropriate influence from the supporter or the perception of it, which may be equally damaging. For example, funding for a patient education brochure should be done with multiple sponsors if possible. For the purposes of this guideline, funding from several companies, but each from a

different and non-competing industry category (e.g., one pharmaceutical manufacturer and one health insurance provider), does not constitute multiple-source funding. Our AMA recognizes that for some activities the benefits may be so great, the harms so minimal, and the prospects for developing multiple sources of funding so unlikely that single-source funding is a reasonable option. Even so, funding exclusivity must be limited to program only (e.g., asthma conference) and shall not extend to a therapeutic category (e.g., asthma). The Board should review single-sponsored activities prior to implementation to ensure that: (i) reasonable attempts have been made to locate additional sources of funds (for example, issuing an open request for proposals to companies in the category); and (ii) the expected benefits of the project merit the additional risk to our AMA of accepting single-source funding. In all cases of single-source funding, our AMA will guard against conflict of interest.
(c) The relationship must preserve AMA's control over any projects and products bearing our AMA name or logo. Our AMA retains editorial control over any information produced as part of a corporate/externally funded arrangement. When an AMA program receives external financial support, our AMA must remain in control of its name, logo, and AMA content, and must approve all marketing materials to ensure that the message is congruent with our AMA's vision and values. A statement regarding AMA editorial control as well as the name(s) of the program's supporter(s) must appear in all public materials describing the program and in all educational materials produced by the program. (This principle is intended to apply only to those situations where an outside entity requests our AMA to put its name on products produced by the outside entity, and not to those situations where our AMA only licenses its own products for use in conjunction with another entity's products.)
(d) Relationships must not permit or encourage influence by the corporate partner on our AMA. An AMA corporate relationship must not permit influence by the corporate partner on AMA policies, priorities, and actions. For example, agreements stipulating access by corporate partners to the House of Delegates or access to AMA leadership would be of concern. Additionally, relationships that appear to be acceptable when viewed alone may become unacceptable when viewed in light of other existing or proposed activities.
(e) Participation in a sponsorship program does not imply AMA's endorsement of an entity or its policies. Participation in sponsorship of an AMA program does not imply AMA approval of that corporation's general policies, nor does it imply that our AMA will exert any influence to advance the corporation's interests outside the substance of the arrangement itself. Our AMA's name and logo should not be used in a manner that would express or imply an AMA endorsement of the corporation, its policies and/or its products.
(f) To remove any appearance of undue influence on the affairs of our AMA, our AMA should not depend on funding from corporate relationships for core governance activities.
Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates, the Board of Trustees and Council meetings could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of our AMA.
(g) Funds from corporate relationships must not be used to support political advocacy activities. A full and effective separation should exist, as it currently does, between political activities and corporate funding. Our AMA should not advocate for a particular issue because it has received funding from an interested corporation. Public concern would be heightened if it appeared that our AMA's advocacy agenda was influenced by corporate funding.
(5) ORGANIZATIONAL REVIEW. Every proposal for an AMA corporate relationship must be thoroughly screened prior to staff implementation. AMA activities that meet certain criteria requiring further review are forwarded to a committee of the Board of Trustees for a heightened level of scrutiny.
(a) As part of its annual report on the AMA's performance, activities, and status, the Board of Trustees will present a summary of the AMA's corporate arrangements to the House of Delegates at each Annual Meeting.
(b) Every new AMA Corporate relationship must be approved by the Board of Trustees, or through a procedure adopted by the Board. Specific procedures and policies regarding Board review are as follows: (i) The Board routinely should be informed of all AMA corporate relationships; (ii) Upon request of two dissenting members of the CRT, any dissenting votes within the CRT, and instances when the CRT and the Board committee differ in the disposition of a proposal, are brought to the attention of the full Board; (iii) All externally supported corporate activities directed to the public should receive Board review and approval; (iv) All activities that have support from only one corporation except patient materials linked to CME, within an industry should either be in compliance with ACCME guidelines or receive Board review; and (f) All relationships where our AMA takes on a risk of substantial financial penalties for cancellation should receive Board review prior to enactment.
(c) The Executive Vice President is responsible for the review and implementation of each specific arrangement according to the previously described principles. The Executive Vice President is responsible for obtaining the Board of Trustees authorization for externally funded arrangements that have an economic and/or policy impact on our AMA.
(d) The Corporate Review Team reviews corporate arrangements to ensure consistency with the principles and guidelines. (i) The Corporate Review Team is the internal, cross-organizational group that is charged with the

review of all activities that associate the AMA's name and logo with that of another entity and/or with external funding. (ii) The Review process is structured to specifically address issues pertaining to AMA's policy, ethics, business practices, corporate identity, reputation and due diligence. Written procedures formalize the committee's process for review of corporate arrangements. (iii) All activities placed on the Corporate Review Team agenda have had the senior manager's review and consent, and following CRT approval will continue to require the routine approvals of the Office of Finance and Office of the General Counsel. (iv) The Corporate Review Team reports its findings and recommendations directly to a committee of the Board.
(e) Our AMA's Office of Risk Management in consultation with the Office of the General Counsel will review and approve all marketing materials that are prepared by others for use in the U.S. and that bear our AMA's name and/or corporate identity. All marketing materials will be reviewed for appropriate use of AMA's logos and trademarks, perception of implied endorsement of the external entity's policies or products, unsubstantiated claims, misleading, exaggerated or false claims, and reference to appropriate documentation when claims are made. In the instance of international publishing of JAMA and the Archives, our AMA will require review and approval of representative marketing materials by the editor of each international edition in compliance with these principles and guidelines.
(6) ORGANIZATIONAL CULTURE AND ITS INFLUENCE ON EXTERNALLY FUNDED PROGRAMS.
(a) Organizational culture has a profound impact on whether and how AMA corporate relationships are pursued. AMA activities reflect on all physicians. Moreover, all physicians are represented to some extent by AMA actions. Thus, our AMA must act as the professional representative for all physicians, and not merely as an advocacy group or club for AMA members.
(b) As a professional organization, our AMA operates with a higher level of purpose representing the ideals of medicine. Nevertheless, non-profit associations today do require the generation of non-dues revenues. Our AMA should set goals that do not create an undue expectation to raise increasing amounts of money. Such financial pressures can provide an incentive to evade, minimize, or overlook guidelines for fundraising through external sources.
(c) Every staff member in the association must be accountable to explicit ethical standards that are derived from the vision, values, and focus areas of the Association. In turn, leaders of our AMA must recognize the critical role the organization plays as the sole nationally representative professional association for medicine in America. AMA leaders must make programmatic choices that reflect a commitment to professional values and the core organizational purpose. (BOT Rep. 20, A-99; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 1, A-03; Modified: CCB/CLRPD Rep. 3, A-12)

Retirement and Hiring Practices H-25.996
It is urged that physicians, individually and through their constituent, component, and specialty medical societies, continue to stress the need to reappraise policies calling for compulsory retirement and age discrimination in hiring from the standpoint of health among older people, and that they participate actively and lend medical weight in the efforts of other groups to create a new climate of opportunity for the older worker. Committee on Aging Report, I-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CCB Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(November 2020)

Introduced by: New York

Subject: Report on the Preservation of Independent Medical Practice

Referred to: Reference Committee F

Whereas, The number of physicians in independent practice of medicine has been rapidly dwindling; and

Whereas, AMA policy is to advocate for the preservation of independent medical practice; and

Whereas, Many physicians are not members of the AMA, possibly because they are not satisfied with or are unaware of the activities of the AMA to help physicians stay in private practice; therefore be it

RESOLVED, That our American Medical Association issue a report every two years communicating their efforts to support independent medical practices. (Directive to Take Action)

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

Received: 10/12/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(November 2020)

Introduced by: Senior Physicians Section

Subject: Timely Promotion and Assistance in Advance Care Planning and Advance Directives

Referred to: Reference Committee F

Whereas, Every human being will confront mortality, and medical care and decision making at the end of life are best managed with the help of Advance Directives[1,2]; and

Whereas, The COVID-19 pandemic has dramatically increased the number of people facing life threatening illness and even end-of-life, concomitantly with limited or no access to their loved ones at the bedside, which situation has exponentially increased stress on physicians and others caring for critically ill patients; and

Whereas, Advance Directives specify the extent of care a person wishes when they are unable to make medical decisions for themselves; and

Whereas, Advance Directives are legal in every state, at no, or very low cost, and easily fillable forms are readily available from a variety of sources e.g. MOLST /POLST, including local medical organizations, AARP, state governments, faith-based groups, hospitals, and online; and

Whereas, The use of Advance Directives has been shown to bring comfort, closure, peace-of-mind, and family support, and to reduce healthcare costs; and

Whereas, Studies show that only about 37% of Americans have completed Advance Directives and even physicians are known to be lax in modeling this beneficial health practice[3]; and

Whereas, The substantially lower rate of completion of advance directives among minority populations has been identified as a health disparity and equity issue; and

Whereas, The source preferred by patients for information about advance care planning is their own physician, and advance care planning discussions between a physician and a patient are now reimbursable, yet it has not become a routine part of medical care; and despite past AMA recommendations, advance directive forms are not yet fully integrated as part of the medical record; and

Whereas, Advance directives, when not routinely completed by patients or when not available to providers because they are not included in a medical record, are sometimes either not considered by, or not honored by providers; therefore be it

RESOLVED, That our American Medical Association: (1) begin an educational and media campaign including billing and reimbursement information for physicians, encouraging physicians to lead by example and complete their own advance directives, to help motivate the routine provision of advance care planning to patients, so as to encourage and equip patients to complete their own advance directives; (2) encourage practicing physicians to publicize the fact of having executed their own advance directives, via educational materials posted and/or available in offices and on websites, as a way of starting the conversation with patients and families; and (3) urge all primary care physicians to immediately begin to include advance care planning as a routine part of their adult patient care protocols, and that advance directives be included in patients' medical records as a matter of course (Directive to Take Action); and be it further

RESOLVED, That our AMA promote outreach (prioritized and made more urgent by the COVID-19 pandemic) on: (1) the importance of advance directives with all its stakeholder groups and with other organizations with which it has relationships; and (2) to the legal, medical, hospital, medical education, and faith-based communities, as well as to interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent (Directive to Take Action); and be it further

RESOLVED, That our AMA formally support the designation of April 16 of every year as National Healthcare Decisions Day. (Directive to Take Action)

Fiscal Note: Estimated cost of implementation in excess of $250K with ongoing annual costs.

Received: 10/05/20

[1] Pollack, K.M; Morhaim, D.; and Williams, MA (2010, June). The Public's Perspectives on Advance Directives: Implications for State Legislative and Regulatory Policy. Health Policy. 96(1):57-63. doi: 10.1016/j.healthpol.2010.01.004. Epub 2010 Jan 27. Retrieved from: https://www.sciencedirect.com/science/article/abs/pii/S0168851010000096 .
[2] Morhaim, D.K.; Pollack, K (2013, June). End-of-Life Care Issues: A Personal, Economic, Public Policy, and Public Health Crisis. American Journal of Public Health (AJPH). 103(6): e8–e10. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3698717/ .
[3] Reuters Health (2017, July 11). Over one third of U.S. Adults have Advanced Medical Directives. Retrieved from: https://www.reuters.com/article/us-health-usa-advance-directives/over-one-third-of-u-s-adults-have-advanced-medical-directives-idUSKBN19W2NO .

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(November 2020)

Introduced by: New York

Subject: Development of Resources on End of Life Care

Referred to: Reference Committee F

Whereas, The questions regarding life and death have been debated by scholars, philosophers, religious leaders and doctors for centuries and technology has blurred the distinction between a quality human life and biological life on a cellular or organ basis; and

Whereas, Economic, social and religious views influence modern definitions of human and biological life, making technology in modern medicine a double-edged sword, favoring the betterment of patients and their quality of life and care; and

Whereas, Physicians have been sworn to do no harm, yet this is increasingly challenging with today's competing forces of technology, shifting social morae's and the economics and legislation of health care; and

Whereas, Confronted/ burdened with the more complicated questions of when life begins and ends, physicians have not always been able to transition patients effectively from life to death, which has contributed to decreased use of tools such as palliative care and hospice care; and

Whereas, End-of-life care as defined by the World Health Organization (WHO) "is the term used to describe the support and medical care given during the time surrounding death"; and

Whereas, Palliative Care is the treatment of patients with serious illnesses and disease with the goal to help the patient feel better, prevent or alleviate symptoms and side effects of disease and treatment, treating the whole patient including the emotional, social, practical, and spiritual costs of that illnesses, striving to improve a patient's quality of life as they deal with serious illness; and

Whereas, Hospice is the treatment of patients at the end of life or with a terminal illness, generally for patients who have less than six months to live and which uses many elements of palliative care to keep patients comfortable during their transition from life to death; and

Whereas, Physicians need to educate themselves on what the treatment goals offer and the reasonableness of the outcome, while all physicians should understand what palliative and hospice care offer a patient in terms of treatment, palliative care is an appropriate bridge to care; and

Whereas, There needs to be more certificate programs for physicians on palliative care until such time as there are enough fellowship trained end of life physicians, education is critical with respect to hospice care which does not mean "no care" but should redefine the scope of care; and

Whereas, Currently, the delivery of end of life care is fragmented with services provided in the hospital, skilled nursing facility or community with each setting having different resources, definitions and protocols and no seamless way to transfer patients from one setting to the next and back again; and

Whereas, The current “one size fits all” approach does little to address the spectrum of end of life issues but reinforces the need for a centralized depository of end of life orders that is easily accessible; therefore be it

RESOLVED, That our American Medical Association develop educational resources for physicians, allied health professionals and patients on end of life care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all stakeholders to develop proper quality metrics to evaluate and improve palliative and hospice care. (Directive to Take Action)

Fiscal Note: Not yet determined

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