DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its November 2020 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (N-20)

Report of Reference Committee on Amendments to Constitution and Bylaws

Charles J. Rainey, MD, JD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION**
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5 1. Board of Trustees Report 18 - Specialty Society Representation in the House of
6 Delegates – Five-Year Review
7 2. Council on Constitution & Bylaws Report 1 – Bylaw Accuracy: Name Change for
8 Accreditation Body for Osteopathic Medical Schools
9 3. Council on Ethical and Judicial Affairs Report 1 – Amendment to Opinion 1.2.2,
10 “Disruptive Behavior and Discrimination by Patients”
11 4. Council on Ethical and Judicial Affairs Report 2 – Amendment to Opinion 8.7,
12 “Routine Universal Immunization of Physicians”
13 5. Resolution 008 – Delegate Apportionment During COVID-19 Pandemic Crisis
14 6. Resolution 011 – Elimination of Race as a Proxy for Ancestry, Genetics, and
15 Biology in Medical Education, Research, and Clinical Practice
16
17 **RECOMMENDED FOR ADOPTION AS AMENDED**
18
19 7. Council on Constitution & Bylaws Report 2 – Discordance between Policy and
20 Bylaws--CEJA Membership on AMA Committee on Conduct at AMA Meetings
21 and Events
22 8. Resolution 005 – Racism as a Public Health Threat
23 9. Resolution 010 – Racial Essentialism in Medicine
24
25 **RECOMMENDED FOR ADOPTION IN LIEU OF**
26
27 10. Resolution 007 – Access to Confidential Health Care Services for Physicians and
28 Trainees
29

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 18 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 18 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 18 adopted and the remainder of the Report filed.

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

1. That the American Academy of Otolaryngic Allergy, American Association of Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Breast Surgeons, American Society of Interventional Pain Physicians, American Society of Retina Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart Rhythm Society, Infectious Disease Society of America, International Society for the Advancement of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the International Academy of Independent Medical Evaluators and the American Society of Abdominal Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year’s grace period to increase membership, the American Society for Aesthetic Plastic Surgery not retain representation in the House of Delegates. (Directive to Take Action)

The report was introduced by a member of the Board of Trustees and no further testimony was heard. Your Reference Committee recommends that Board of Trustees Report 18 be adopted.

(2) COUNCIL ON CONSTITUTION & BYLAWS REPORT 1 – BYLAW ACCURACY: NAME CHANGE FOR ACCREDITATION BODY FOR OSTEOPATHIC MEDICAL SCHOOLS

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the Report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

1.1 Categories.

Categories of membership in the American Medical Association (AMA) are: Active Constituent, Active Direct, Affiliate, Honorary, and International.

1.1.1 Active Membership.

1.1.1.1 Active Constituent. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation ~~American Osteopathic Association~~ leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.2 Active Direct. Active direct members are those who apply for membership in the AMA directly. Applicants residing in states where the constituent association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the Federal Services that have

been granted representation in the House of Delegates. Active direct members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation ~~American Osteopathic Association~~ leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

The report was introduced by the Council, and the limited testimony heard was supportive of the report. Your Reference Committee therefore recommends that Council on Constitution and Bylaws Report 1 be adopted.

(3) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 – AMENDMENT TO OPINION 1.2.2, "DISRUPTIVE BEHAVIOR AND DISCRIMINATION BY PATIENTS"

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 1 adopted and the remainder of the report filed.

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; that the title of Opinion 1.2.2, be amended to read "Disruptive Behavior and Discrimination by Patients"; that the body of Opinion 1.2.2 be amended by addition and deletion as follows; and the remainder of this report be filed:

The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.

Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either ~~physicians~~ patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.

(b) Always treat patients with compassion and respect.

(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) Prioritize the goals of care when deciding whether to decline or accommodate a patient's ~~prejudiced~~ request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.

(e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests.

(f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.

(g) Terminate the patient-physician relationship ~~who uses derogatory language or acts in a prejudiced manner~~ only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient's control, in keeping with ethics guidance.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

(i) Educate staff, patients, and the community about the institution's expectations for behavior.

(j) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.

(I) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.

Mixed testimony was heard on this report. Speakers noted that the type of discriminatory, abusive, and disruptive behavior referenced in this report seems to be increasing and is thus critically important to address at this time. Other speakers approvingly noted that the report effectively offered protections to physicians. Opposing testimony, recommending referral, questioned certain clauses in the report's recommendations and expressed concern that as written would only allow physicians to refuse a patient under specific circumstances, and in addition, don't account for emergency situations. However, your Reference Committee believes that Principle VI of the *Code of Medical Ethics*, which states that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" addresses this sufficiently. Concerns were also raised regarding the feasibility of collecting data on these policies, but your Reference Committee believes that these clauses simply refer to medical practices examining the efficacy of their own policies. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 – AMENDMENT TO OPINION 8.7, "ROUTINE UNIVERSAL IMMUNIZATION OF PHYSICIANS"

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 2 adopted and the remainder of the report filed.

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that Opinion 8.7, "Routine Universal Immunization of Physicians," be amended by insertion and deletion as follows and that the remainder of this report be filed:

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine

infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians ~~should:~~

~~Accept~~ have a responsibility to accept immunization absent a recognized medical~~, religious, or philosophic reason to not be immunized~~ contraindication or when a specific vaccine would pose a significant risk to the physician's patients.
~~(b) Accept a decision of the medical staff leadership or health care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status.~~

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.

Testimony largely supported this report. Speakers noted that vaccine resistance and hesitancy is increasing among patients and non-physician healthcare practitioners alike, and that it is essential that the medical profession serve as an example on this matter. Other testimony noted that the report is appropriately consistent with advice given by physicians to their patients. Speakers noted that this is an urgent issue given the COVID-19 pandemic, and that as the organization representing medicine and science, the AMA should act on those principles. Testimony also noted that H-440.970, "Nonmedical Exemptions from Immunizations" holds that "nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large."

Some speakers stated that banning philosophical and religious exceptions is unconstitutional, but others countered that philosophical and religious exemptions are often used in ways that are invalid. Further, regardless of the reason for declining vaccination, physicians who do decline vaccination should modify their roles to avoid direct

patient-facing care as stated in the recommendations. Your Reference Committee recommends that CEJA Report 2 be adopted and the remainder of the report be filed.

(5) RESOLUTION 008 – DELEGATE APPORTIONMENT DURING COVID-19 PANDEMIC CRISIS

RECOMMENDATION:

Resolution 008 be <u>adopted</u>.

HOD ACTION: Resolution 008 <u>adopted</u>.

RESOLVED, That our American Medical Association extend the current grace period from one year to two years for losing a delegate from a state medical or national medical specialty society until the end of 2022. (Directive to Take Action)

Limited testimony was heard in support of Resolution 008. Your Reference Committee recommends that Resolution 008 be adopted.

(6) RESOLUTION 011 – ELIMINATION OF RACE AS A PROXY FOR ANCESTRY, GENETICS, AND BIOLOGY IN MEDICAL EDUCATION, RESEARCH, AND CLINICAL PRACTICE

RECOMMENDATION:

Resolution 011 be <u>adopted</u>.

HOD ACTION: Resolution 011 <u>adopted</u>.

RESOLVED, That our American Medical Association recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology (New HOD Policy); and be it further

RESOLVED, That our AMA support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice (New HOD Policy); and be it further

RESOLVED, That our AMA encourage undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (1) demonstrates how the category “race” can influence health outcomes; (2) that supports race as a social construct and not a biological determinant and (3) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result

in racial health disparities (New HOD Policy); and be it further

RESOLVED, That our AMA recommend that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease. (Directive to Take Action)

Testimony was unanimously in support of Resolution 011, reiterating that – as evidence clearly supports – race is a social rather than biological construct. Speakers emphasized that this is a critical issue facing our country, and because racism is a broadly embedded issue in medical research and scholarship, the AMA must work to combat racism throughout the profession. As such, using the more precise and accurate data markers of ancestry, genetics, and biology, as well as other indicators such as zip code and education, where appropriate, instead of race, will contribute to better outcomes and, hopefully, increase health equity. Further testimony noted that it is not sufficient for medicine to be non-racist, but that medicine must be anti-racist. Your Reference Committee recommends that Resolution 011 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) COUNCIL ON CONSTITUTION & BYLAWS REPORT 2 – DISCORDANCE BETWEEN POLICY AND BYLAWS-- CEJA MEMBERSHIP ON AMA COMMITTEE ON CONDUCT AT AMA MEETINGS AND EVENTS

RECOMMENDATION A:

Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," be amended by addition to read as follows:

> **1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)**
>
> **…**
>
> **The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.**

RECOMMENDATION B:

Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," be adopted as amended.

RECOMMENDATION C:

Recommendations in Council on Constitution and Bylaws Report 2 adopted and the remainder of the Report filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 2 adopted, the remainder of the Report be filed, and Policy H-140.837 adopted as amended.

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Constitution and Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

6.5 Council on Ethical and Judicial Affairs.

6.5.5 Membership.

6.5.5.1 Nine active members of the AMA, one of whom shall be a resident/fellow physician and one of whom shall be a medical student. Members elected to the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy.

Limited and mixed testimony was heard on this report. The Reference Committee recognizes that the original purpose of this report was to reconcile the discordance created by policy adopted at A-19 requiring a member of CEJA be on CCAM, and the bylaws pertaining to CEJA. Your Reference Committee believes this to have been accomplished with the original recommendation of CCB 2.

However, a separate issue was raised during testimony regarding a potential conflict of interest for the CEJA member when cases brought before CCAM concern possible referral by the CCAM of a matter to CEJA for further review and action.

Your Reference Committee acknowledges that a conflict of interest might exist in those situations, and that it is not appropriate for an individual to participate both as a member of CCAM and member of CEJA for the same case. Your Reference Committee consulted with the Office of General Counsel on the most appropriate way to address this issue. As a result, your Reference Committee recommends that H-140.837, “Policy on Conduct at AMA Meetings and Events,” be amended to address the perceived conflict.

Therefore, your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted, and HOD-140.837 be adopted as amended.

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(8) RESOLUTION 005 – RACISM AS A PUBLIC HEALTH THREAT

RECOMMENDATION A:

The first Resolve of Resolution 005 be amended by addition and deletion.

RESOLVED, That our American Medical Association acknowledge that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery ~~historic and present racist medical practices~~ have caused and continue to cause harm to marginalized communities and society as a whole (New HOD Policy);

RECOMMENDATION B:

The third Resolve of Resolution 005 be amended by addition.

RESOLVED, That our AMA identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations (Directive to Take Action);

RECOMMENDATION C:

Resolution 005 be adopted as amended.

HOD ACTION: Resolution 005 adopted as amended.

RESOLVED, That our American Medical Association acknowledge that historic and present racist medical practices have caused and continue to cause harm to marginalized communities (New HOD Policy); and be it further

RESOLVED, That our AMA recognize racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care (New HOD Policy); and be it further

RESOLVED, That our AMA identify a set of current best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, and populations (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:

1. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and
2. How to prevent and ameliorate the health effects of racism (New HOD Policy); and be it further

RESOLVED, That our AMA: (a) support the development of policy to combat racism and its effects; (b) encourage governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them (New HOD Policy); and be it further

RESOLVED, That our AMA work to prevent and combat the influences of racism and bias in innovative health technologies. (Directive to Take Action)

Testimony strongly supported this resolution with amendments proffered in the Online Forum by the original author in collaboration with other groups. Speakers noted that it is essential for the house of medicine to acknowledge historical racism and that racism in all its forms is a public health threat. Testimony widely supported the first resolve as amended. The second resolve was lauded as consistent with AMA policy and would strengthen future AMA advocacy efforts. While testimony was also offered suggesting that the third through sixth resolves be referred, a number of speakers suggested that the topic has been thoroughly studied and that referral is unnecessary. Your Reference Committee agrees that referral is not needed.

Importantly, testimony called attention to the fact that IMG's as a group have been significantly impacted by the effects of racism, which has been highlighted by the pandemic. There was overwhelming support of the amendment to include this overlooked group in the third resolve.

Your Reference Committee would like to acknowledge that there was significant discussion regarding the phrase "racist medical practices," which was used in the original language of the first resolve. It was suggested that such phrasing was imprecise and inflammatory, but others responded, and your Reference Committee agrees, that the phrase reflects fact and history. However, this discussion did not affect the enthusiasm for the previously noted amendment to the first resolve because the amendment doesn't include this phrase.

Your Reference Committee recommends that Resolution 005 be adopted as amended.

(9) RESOLUTION 010 – RACIAL ESSENTIALISM IN MEDICINE

RECOMMENDATION A:

The Third Resolve in Resolution 010 be <u>amended by addition and deletion</u>.

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders ~~organizations~~, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate ~~be perpetuating~~ teachings, assessments, and practices that reinforce institutional and structural racism ~~the mistaken belief that race is an inherent biologic risk factor for diseases~~ (Directive to Take Action)

RECOMMENDATION B:

Resolution 010 be adopted as amended.

HOD ACTION: Resolution 010 adopted as amended.

RESOLVED, That our American Medical Association recognize that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the AAMC, AACOM, NBME, NBOME, ACGME, other appropriate stakeholder organizations, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors (Directive to Take Action); and be it further

RESOLVED, That our AMA support research that promotes antiracist strategies to mitigate algorithmic bias in medicine. (Directive to Take Action)

Virtually all testimony strongly supported Resolution 010. In the online forum, the authors of the resolution provided the amendments shown above. They did so in response to concerns about unintended consequences and the potential vague nature of the original language. Testimony in the Online Forum and in the reference committee hearing agreed with the changes, as the amended resolve is much more precise: changing "organizations" to "stakeholders" allows for broader inclusion of appropriate parties to join future efforts,

and the other changes now identify specific practices that perpetuate institutional and structural racism.

The few speaking against adoption as originally written suggested that the first three resolve clauses were based on opinion or limited evidence, but a number of speakers countered that assertion, reiterating that race is undeniably a social construct and should be treated as such. Others agreed, citing studies that demonstrate the false conflation of race with biological and genetic traits and the resulting detrimental outcomes for patients. Testimony also noted that the resolution is consistent with previous AMA statements.

An amendment was discussed regarding changing “support” to “encourage” in the fifth resolve clause, but testimony, including that from the authors, led to the original language being retained as it gives the AMA a much more active role in addressing these issues directly.

Your Reference Committee agrees with the rationale and language of the proffered amendments and thus recommends that Resolution 010 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(10) RESOLUTION 007 – ACCESS TO CONFIDENTIAL HEALTH CARE SERVICES FOR PHYSICIANS AND TRAINEES

RECOMMENDATION A:

That the following Resolution be adopted in lieu of Resolution 007:

RESOLVED, That our American Medical Association advocate that: (1) physicians, medical students and all members of the health care team (a) maintain self-care, and (b) are supported by their institutions in their self-care efforts, and (c) **in order to maintain the confidentiality of care ~~when they have concerns about psychiatric or substance-related symptoms that are not responding to self-care~~,** have access to affordable health care, including mental and physical health care, **~~have the opportunity to seek appropriate care~~ outside of their place of work or education; (2) employers** support access to mental and physical health care **~~do all they can,~~ including but not limited to providing ~~promoting~~ access to ~~providers~~ out-of-network in person and/or** via **telemedicine,** thereby **reducing stigma, eliminating discrimination, and removing other barriers to treatment ~~entry, for those who need professional behavioral health care services~~ (New HOD Policy); and be it further**

RESOLVED, That our AMA advocate for **~~study~~ best practices to ensure physicians, medical students and** all members of the **health care team~~s~~ have access to appropriate behavioral,** mental, primary, and specialty **health care and addiction services~~, as affected by deductibles, copays, coinsurance, out-of-pocket maximums and access to out-of-network providers~~. (Directive to Take Action)**

RECOMMENDATION B:

Alternate Resolution 007 be adopted in lieu of Resolution 007.

HOD ACTION: Alternate Resolution 007 adopted in lieu of Resolution 007.

RESOLVED, That our American Medical Association advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors, should encourage them to maintain self-care and to seek professional help from a mental health professional or addiction professional when they have concerns about psychiatric or substance-related symptoms that are not responding to self-care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that employers of physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors should do all they can to reduce stigma, reduce or eliminate discrimination, and remove barriers to treatment entry for those who need professional behavioral health care services (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that employers in the health care sector including academic medical centers where residents and fellows are trained, as well as medical schools, who offer health benefits to their employees, fellows, residents and medical students, and where there is a defined set of in-network providers, should assure that physicians, other licensed independent professionals, advance practice practitioners, nurses, mental health therapists and addiction counselors are able to go out-of-network to see a mental health or addiction professional who does not work in the same health system as the employee (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that fellows, residents and medical students be provided access to out-of-network providers when they are seeking to establish care with a primary care provider, so that they are able to use their health insurance benefits while not finding themselves under the care of a past, current or future faculty member, if the original provider network does not contain adequate options for primary care offered by clinicians not on the faculty of the medical school or academic medical center; (Directive to Take Action) and be it further

RESOLVED, That our AMA advocate that contracts should be established by medical schools, academic medical centers, and employers of practicing physicians such that the deductibles, copays, coinsurance, and out-of-pocket maximums for such practicing physicians, fellows, residents and medical students seeing out-of-network providers of mental health, addiction, and primary medical care should be the same as the deductibles, copays, coinsurance, and out-of-pocket maximums for seeing in-network providers. (Directive to Take Action)

Testimony was heard in support of the goals of Resolution 007. Speakers noted that physicians and medical trainees experience high levels of burnout, often do not receive mental health care, and are hesitant to reach out for mental health care due to stigma and concerns about job loss due to issues with confidentiality. Testimony also noted that this crisis has been exacerbated by the COVID-19 pandemic.

Some speakers suggested modifying the language to narrow the focus on physicians and physicians in training. Others suggested additional language to include advocacy for state and federal legislation. Other concerns included the need to specifically include addiction, existing systems for medical students to receive mental health care outside of their

1 system, and the feasibility of finding a physician-led team when practicing in rural areas.
2 All speakers noted the urgency of this issue in general and the need for AMA action.
3
4 All in all, your Reference Committee agrees that this is an urgent issue that our AMA
5 should address now, yet also deserves further study to address the specific concerns
6 regarding implementation. As such, your Reference Committee has offered resolves in
7 lieu of the original resolves, and recommends that Alternate Resolution 007 be adopted in
8 lieu of Resolution 007.
9

1 Madam Speaker, this concludes the report of Reference Committee on Amendments to
2 Constitution and Bylaws. I would like to thank Jade Anderson, MD, Kyle P. Edmunds,
3 MD, Tristan Mackey, Thomas G. Peters, MD, Peter H. Rheinstein, MD, JD, MS, Roxanne
4 Tyroch, MD, and all those who testified before the Committee.
5

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