AMA
AMERICAN MEDICAL ASSOCIATION

MEMBERSHIP MOVES MEDICINE™

JUNE 2021

Special Meeting of the AMA House of Delegates

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

• All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items THAT MAY BE CONSIDERED by the House.

- **ALL ITEMS HAVE NOT YET BEEN REVIEWED BY THE RESOLUTIONS COMMITTEE FOR PRIORITY/URGENCY FOR THIS SPECIAL MEETING**

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

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

• REMINDER*: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.*

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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 Numbers are deleted and not reused when policies are rescinded.

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

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

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

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

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

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

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

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

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

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK

JUNE 2021 SPECIAL MEETING OF THE AMA HOUSE OF DELEGATES

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Friday, June 11, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles and Responsibilities**

5. **Seating Chart**

6. **Official Call to the Officers and Members of the AMA**
   Listing of Delegates and Alternate Delegates
   Officials of the Association and AMA Councils

7. **Note on Order of Business**

8. **Reference Committee Hearings**

9. **Reference Committee Members**

10. **Summary of Fiscal Notes**

FOLLOWING COLLATED BY REFERRAL

11. Report(s) of the Board of Trustees - Russ Kridel, MD, Chair

01 Annual Report (F)

02 2020 Grants and Donations (Info. Report)

03 AMA 2022 Dues (F)

04 Update on Corporate Relationships (Info. Report)

05 AMA Performance, Activities and Status in 2020 (Info. Report)

06 Annual Update on Activities and Progress in Tobacco Control: March 2020 Through February 2021 (Info. Report)

07 Council on Legislation Sunset Review of 2011 House Policies (B)

08 Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report) (Info. Report)

09 Preservation of the Patient-Physician Relationship (G)

10 Protestor Protections (D)

11 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)

12 Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment (F)

13 Amending the AMA's Medical Staff Rights and Responsibilities (G)

14 Pharmaceutical Advertising in Electronic Health Record Systems (B)

15 Removing Sex Designation from the Public Portion of the Birth Certificate (D)

16 Follow-up on Abnormal Medical Test Findings (D)

17* Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

18* Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19 (B)

12. Report(s) of the Council on Constitution and Bylaws - Madelyn E. Butler, MD, Chair

01* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs (Amendments to C&B)

02* AMA Women Physicians Section: Clarification of Bylaw Language (Amendments to C&B)

03* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section) (Amendments to C&B)

13. Report(s) of the Council on Ethical and Judicial Affairs - Monique A. Spillman, MD, Chair

01* CEJA's Sunset Review of 2011 House Policies (Amendments to C&B)

02* Short-term Medical Service Trips (Amendments to C&B)

03* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues" (Amendments to C&B)

04* Augmented Intelligence & the Ethics of Innovation in Medicine (Info. Report)

05* Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report (Info. Report)

14. Opinion(s) of the Council on Ethical and Judicial Affairs - Monique A. Spillman, MD, Chair

01* Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients (Info. Report)

02* Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians" (Info. Report)

15. Report(s) of the Council on Long Range Planning and Development - Shannon Pryor, MD, Chair

01* Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)

16. Report(s) of the Council on Medical Education - Liana Puscas, MD, Chair

01* Council on Medical Education Sunset Review of 2011 House Policies (C)

02* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (C)

03* Optimizing Match Outcomes (C)

04* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (C)

05* Promising Practices Among Pathway Programs to Increase Diversity in Medicine (C)

17. Report(s) of the Council on Medical Service - Lynda M. Young, MD, Chair

01* Council on Medical Service's Sunset Review of 2011 House Policies (G)

02* Continuity of Care for Patients Discharged from Hospital Settings (A)

03* Universal Basic Income Pilot Studies (G)

04* Promoting Accountability in Prior Authorization (G)

05* Medical Center Patient Transfer Policies (G)

06* Urgent Care Centers (G)

07* Addressing Equity in Telehealth (A)

08* Licensure and Telehealth (A)

09* Addressing Payment in Delivery in Rural Hospitals (G)

18. Report(s) of the Council on Science and Public Health - Kira A. Geraci-Ciardullo, MD, Chair

01* Council on Science and Public Health Sunset Review of 2011 House Policies (D)

02* Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings (E)

03* Addressing Increases in Youth Suicide (D)

19. Joint Report(s)

01* CCB/CLRPD Joint Council Sunset Review of 2011 House Policies (F)

20. Report(s) of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker

01 Recommendations for Policy Reconciliation (Info. Report)

02 Report of the Election Task Force (Amendments to C&B)

21. Resolutions

001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD) (Amendments to C&B)

002 Sharing Covid-19 Resources (Amendments to C&B)

003* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions (Amendments to C&B)

004* AMA Resident/Fellow Councilor Term Limits (Amendments to C&B)

005* Resident and Fellow Access to Fertility Preservation (Amendments to C&B)

006* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients (Amendments to C&B)

007* Nonconsensual Audio/Video Recording at Medical Encounters (Amendments to C&B)

008* Organ Transplant Equity for Persons with Disabilities (Amendments to C&B)

009* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties (Amendments to C&B)

010* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses (Amendments to C&B)

011* Truth, Reconciliation and Healing in Medicine and Medical Education (Amendments to C&B)

012* Increasing Public Umbilical Cord Blood Donations in Transplant Centers (Amendments to C&B)

013* Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism (Amendments to C&B)

014* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities (Amendments to C&B)

015* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals (Amendments to C&B)

016* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (Amendments to C&B)

017* Improving the Health and Safety of Sex Workers (Amendments to C&B)

018* LGBTQ+ Representation in Medicine (Amendments to C&B)

019* Evaluating Scientific Journal Articles for Racial and Ethnic Bias (Amendments to C&B)

020* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954 (Amendments to C&B)

021* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions (Amendments to C&B)

101 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits (A)

102 Bundling Physician Fees with Hospital Fees (A)

103 COBRA for College Students (A)

104 Medicaid Tax Benefits (A)

105 Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums (A)

106 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? (A)

107* Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance (A)

108* Implant Associated Anaplastic Large Cell Lymphoma (A)

109* Support for Universal Internet Access (A)

110* Healthcare Marketplace Plan Selection (A)

111* Towards Prevention of Hearing-Loss Associated Cognitive Impairment (A)

112* Fertility Preservation Benefits for Active-Duty Military Personnel (A)

113* Support for Universal Internet Access (A)

114* Reimbursement of School-Based Health Centers (A)

115* Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration (A)

116* Caps on Insulin Co-Payments for Patients with Insurance (A)

117* Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System (A)

201 Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication (B)

202 Prohibit Ghost Guns (B)

203 Ban the Gay/Trans (LGBTQ+) Panic Defense (B)

204 Insurers and Vertical Integration (B)

205 Protection of Peer-Review Process (B)

206* Redefining the Definition of Harm (B)

207* Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education (B)

208* Increasing Residency Positions for Primary Care (B)

209* Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research (B)

210* Ransomware and Electronic Health Records (B)

211* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients (B)

212* ONC's Information Blocking Regulations (B)

213* CMMI Payment Reform Models (B)

214* Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities (B)

215* Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs (B)

216* Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies (B)

217* Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19 (B)

218* Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity (B)

219* Oppose Tracking of People who Purchase Naloxone (B)

220* Equal Access to Adoption for the LGBTQ Community (B)

221* Support for Mental Health Courts (B)

222* Advocating for the Amendment of Chronic Nuisance Ordinances (B)

223* Supporting Collection of Data on Medical Repatriation (B)

224* Using X-Ray and Dental Records for Assessing Immigrant Age (B)

301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic (C)

302 Non-Physician Post-Graduate Medical Training (C)

303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE (C)

304* Decreasing Financial Burdens on Residents and Fellows (C)

305* Non-Physician Post-Graduate Medical Training (C)

306* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training (C)

307* Updating Current Wellness Policies and Improving Implementation (C)

308* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure (C)

309* Supporting GME Program Child Care Residency Training (C)

310* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine (C)

311* Student Loan Forgiveness (C)

312* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs (C)

313* Fatigue Mitigation Respite for Faculty and Residents (C)

314* Standard Procedure for Accommodations in USMLE and NBME Exams (C)

315* Representation of Dermatological Pathologies in Varying Skin Tones (C)

316* Improving Support and Access for Medical Students with Disabilities (C)

401 Universal Access for Essential Public Health Services (D)

402 Modernization and Standardization of Public Health Surveillance Systems (D)

403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America (D)

404* Support for Safe and Equitable Access to Voting (D)

405* Traumatic Brain Injury and Access to Firearms (D)

406* Attacking Disparities in Covid-19 Underlying Health Conditions (D)

407* Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities (D)

408* Screening for HPV-Related Anal Cancer (D)

409* Weapons in Correctional Healthcare Settings (D)

410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis (D)

411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens (D)

412* Addressing Maternal Discrimination and Support for Flexible Family Leave (D)

413* Call for Increased Funding and Research for Post Viral Syndromes (D)

414* Call for Improved Personal Protective Equipment Design and Fitting (D)

415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles (D)

416* Expansion on Comprehensive Sexual Health Education (D)

417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925 (D)

418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV (D)

419* Student-Centered Approaches for Reforming School Disciplinary Policies (D)

501 Ensuring Correct Drug Dispensing (E)

502 Scientific Studies Which Support Legislative Agendas (E)

503 Access to Evidence-Based Addiction Treatment in Correctional Facilities (E)

504* Healthy Air Quality (E)

505* Personal Care Product Safety (E)

506* Wireless Devices and Cell Tower Health and Safety (E)

507* Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues (E)

601* $100 Member Annual Dues Payment Through 2023 (F)

602* Timely Promotion and Assistance in Advance Care Planning and Advance Directives (F)

603* AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels (F)

604* Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis (F)

605* Amending G-630.140, Lodging, Meeting Venues and Social Functions (F)

606* AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations (F)

701 Physician Burnout is an OSHA Issue (G)

702 Addressing Inflammatory and Untruthful Online Ratings (G)

703 Employed Physician Contracts (G)

704 Eliminating Claims Data for Measuring Physician and Hospital Quality (G)

705* Improving the Prior Authorization Process (G)

706* Prevent Medicare Advantage Plans from Limiting Care (G)

707* Financial Incentives for Patients to Switch Treatments (G)

708* Medicare Advantage Record Requests (G)

* *Contained in the Handbook Addendum*

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

Preamble

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

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

Declaration

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

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

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

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

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

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

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

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

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

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

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

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

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

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

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

JUNE 2021 SPECIAL MEETING OF THE AMA HOUSE OF DELEGATES

SEATING CHART

Your speakers have determined that each participant at the Special Meeting may sit anywhere they wish so long as whomever is sitting near you doesn't object. This will be left to the discretion of the individuals with whom you must live.

To: Delegates and Alternate Delegates

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

Date: March 22, 2021

Subject: J21-HOD: Official Call to the June 2021 Special Meeting of the AMA House of Delegates

Pursuant to the action of the American Medical Association (AMA) Board of Trustees (Board) on March 11, 2021, this notice will serve as the Official Call to convene a Special Meeting of the AMA House of Delegates (HOD) on June 11-16, 2021. The purpose of this meeting, as defined by the action of the Board, is to accomplish **leadership transitions that would otherwise be addressed in association with an Annual Meeting of the HOD and to conduct priority business of the Association.** This Special Meeting will be convened on the same platforms, Lumi and Zoom, that were used at the November 2020 Special Meeting.

The House will commence with the Opening Session at 7 pm CDT, Friday, June 11. We anticipate that we will utilize all of the scheduled days through Wednesday until our business is completed. **Note: We will NOT have a hard stop on Wednesday, June 16,** as there is no need for travel time and this day should have already been cleared on your calendars.

BUSINESS OF THE HOUSE:

Although your Board and Speakers recognize that there is an abundance of business that has been left unattended over the past year, the inherent inefficiencies of a virtual meeting demand a prioritization of the business to be considered, thus the Board motion specified that the purpose of the meeting is to conduct leadership transition and priority business.

To accomplish leadership transition, nominations will be accepted during the Opening Session of the House on Friday evening with election by acclamation of any unopposed candidates. Elections for the remaining races will be held at a specific Election Session on Tuesday morning. The Inauguration of Gerald E. Harmon, MD will occur on Tuesday, June 15 at 6 pm CDT.

In keeping with the defined purpose of this Special Meeting, all delegates and delegations are strongly encouraged to submit only priority resolutions. Our councils and the Board have been asked to do the same. To facilitate the prioritization process, **resolutions MUST BE ACCOMPANIED by a statement of priority (not to exceed 250 words)**, and if submitting more than 1 resolution, **delegations MUST RANK their resolutions in order of priority**. Resolutions submitted without these required elements will not be accepted.

A Resolution Committee will be convened to review all resolutions and make recommendations to the House regarding the priority of the resolutions. Your submitted prioritization statement and ranking will be considered by the Resolution Committee as a factor in their recommendation to the House. The final determination of the business to be considered by the House at this Special Meeting will be decided by majority vote during the Opening Session of the House.

In response to comments received from the Federation, the Resolution Committee will be expanded and the prioritization process has been updated. The *Prioritization Matrix* previously adopted by the

Resolution Committee at the November Special Meeting has been modified for use at this meeting. It is attached and will be posted on the AMA website. Delegates considering submitting a resolution are encouraged to review this matrix. The detailed *Prioritization Process* will also be posted on the AMA website.

ONLINE FORUMS:

Online Forums will once again be open for comment on all submitted resolutions and reports. Your Speakers request that all authors please present an opening comment regarding your resolutions/report. In addition, we ask that members comment not only on the merits of the proffered resolution/report, but also to the priority of the resolutions. **Your Speakers strongly encourage the use of the Online Forum to facilitate the live deliberations.** As a reminder, there is no limit on debate via the Online Forum, however, there will be a limit at the live hearing.

To further encourage use of the Online Forums, the Reference Committees will be instructed to give equal weight to testimony presented in the Online Forums to that presented at the live hearings.

REFERENCE COMMITTEES:

Reference Committees are scheduled Saturday morning and afternoon and Sunday morning. Reference Committee Reports will be posted as soon as available. Sunday afternoon and early morning Monday have been kept open on the schedule to allow for Delegations to consider the reports.

HOUSE OF DELEGATES SESSIONS:

The Opening Session of the House will be held Friday, June 11 at 7 pm CDT. The House will consider Reference Committee Reports beginning at 10 am CDT Monday, on Tuesday following an Election Session, and continuing on Wednesday until all business has been completed. Please keep open Wednesday afternoon as we do not know when we will adjourn.

See attached preliminary agenda for further details.

Your Speakers are sensitive to the fact that our schedule may continue past sundown on Friday and on through Sunday. Delegates for whom this schedule potentially creates a conflict may wish to coordinate with their alternate delegates. Saturday and Sunday will include reference committees where attendance is optional, and individuals are reminded of the opportunity to present testimony in the Online Forum which will be open for several weeks. If further accommodations are needed please contact us at HOD@ama-assn.org.

EMAIL ADDRESSES:

Although this notice is being sent both electronically and by postal mail, delivery delays and the need to expedite communication as we approach the upcoming meeting necessitate that we have correct email addresses for ALL members of the HOD including alternate delegates and any other involved individuals. Email will once again be our primary method of sharing important information, including delegate credentials, with the House. In some cases this notice may have been sent to “spam” or been removed by a security filter. If you receive this notice by postal mail only, you need to confirm your email address and check your filters.

In addition, because delegation rosters may have changed since our November Special Meeting, **we remind delegation chairs and/or staff to confirm that all delegation members have received this communication electronically**. If you or a member of your delegation needs to correct or update their email address, please contact the HOD office at HOD@ama-assn.org immediately.

CAMPAIGNS:

Given the virtual nature of this meeting, all interviews and other campaign activities will be conducted electronically. **All delegations/caucuses who anticipate holding interviews MUST submit to the HOD office prior to Friday, April 30 the name and contact information for the individual in charge of scheduling your interviews. Interviews may be scheduled between May 21 and June 10, 2021.** The HOD office will once again this year be sending an electronic message on behalf of candidates who wish to participate and will be recording interviews of all Board and Council candidates which will be posted on our website. Your speakers will be sending out further instructions to candidates and their campaigns.

COMMITTEE VOLUNTEERS:

Your Speakers are seeking multiple volunteers who are experienced in working via a virtual meeting format; therefore, our usual embargo on those who have served in the recent past will not be observed. If you are interested in serving on one of the Reference Committees, the Rules & Credentials Committee, or the Resolutions Committee, please submit a *"Committee Volunteer Form,"* which is attached to this call or can be downloaded from The Speaker's Page on the AMA site.

FINAL REMINDERS:

Please watch for further communication from us as details are finalized. As a reminder, notices regarding the upcoming June meeting will have ***J21-HOD*** in the subject line (which is short for the June 2021 meeting of the AMA House of Delegates) and will be sent from ama.delegates@groups.ama-assn.org. Please add this address to your contact list.

Your Speakers share your disappointment that circumstances have once again prevented us from meeting in person, but rest assured that plans are well underway to facilitate the policymaking role of our House of Delegates in a fair and deliberative fashion and to conduct elections securely.

<u>TENTATIVE AGENDA</u> *(Central Daylight Time)*:

Wednesday, May 12

Resolution Submission Deadline
Societies whose meetings adjourn after May 12 will have 7 days from their adjournment to submit their priority business but no later than June 6.
NOTE: Reports and resolutions will be posted to the Online Member Forum as soon as possible.

Wednesday, June 2

Resolution Committee First Report Posted

Sunday, June 6

4:00 pm Deadline for late or supplemental resolution submission ("Sunday Tote")

Tuesday, June 8

Resolutions Committee Second Report Posted
Extractions from Second Report accepted
Comments regarding extractions may be posted to Online Forum

Wednesday, June 9

7:00 pm Evening Practice session for HOD *(all encouraged to participate)*
midnight Extraction period from Resolution Committee Second Report closes

Thursday, June 10

noon Resolution Committee Final Report posted

Friday, June 11, 7:00-9:00 pm

HOD Opening Session
Speeches
Nominations
Rules and Credentials Committee Report
Resolution Committee Final Report considered by HOD

Saturday, June 12

9:00 am-12:30 pm Reference Committee Hearings
1:00-4:30 pm Reference Committee Hearings

Sunday, June 13

9:00 am-12:30 pm Reference Committee Hearings
Optional time *for caucuses to review reference committee reports*

Monday, June 14

Optional time *for caucuses to review remaining reference committee reports*

10:00 am-6:00 pm HOD Business Session (lunch break TBD)

Tuesday June 15

9:00 am Election Session

Start Time to be announced HOD Business Session

12:00-1:00 pm AMPAC Capitol Club Luncheon

1:00-5:30 pm HOD Business Session

6:00 pm Inauguration of Gerald E. Harmon, MD

Wednesday (6/16)

9:00 am HOD Business Session until business complete

JUNE 2021 MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (J21 HOD)

Official Call to the Officers and Members of the American Medical Association to participate in the June 2021 Meeting of the AMA House of Delegates (J21-HOD) on June 11-16, 2021. The House of Delegates will convene at 7 p.m. (CT) on June 11, on a virtual platform.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

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

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 4
American Academy of Family Physicians 16
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 2
American Academy of Sleep Medicine 2
American Association of Clinical Endocrinologists 2
American Association of Gynecologic Laparoscopists 3
American Association of Neurological Surgeons 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2
American College of Cardiology 7
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 8
American College of Gastroenterology 2
American College of Obstetricians and Gynecologists 14
American College of Occupational and Environmental Medicine 2
American College of Physicians 34
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 7
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 2
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society for Reproductive Medicine 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 7
American Society of Breast Surgeons 2
American Society of Cataract and Refractive Surgery 2
American Society of Clinical Oncology 3
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Interventional Pain Physicians 2
American Society of Nuclear Cardiology 2
American Society of Plastic Surgeons 2
American Society of Retina Specialists 2
American Thoracic Society 3
American Urological Association 2
Association of Military Surgeons of the United States 2
College of American Pathologists 4
Congress of Neurological Surgeons 2
Heart Rhythm Society 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Renal Physicians Association 2
Society for Vascular Surgery 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Interventional Radiology 2
Society of Laparoscopic and Robotic Surgeons 2
Society of Thoracic Surgeons 2
The Endocrine Society 2
United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (58) are entitled to one delegate each.

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

State Medical Associations	306
National Medical Specialty Societies	304
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	27
Resident and Fellow Delegate Representatives	32
Sections	11
Services	5
Total Delegates	**691**

Susan R. Bailey, MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Sandra Adamson Fryhofer, MD
Secretary

2020-2021

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President – Susan R. Bailey.....Fort Worth, Texas
President-Elect – Gerald E. Harmon.....Pawleys Island, South Carolina
Immediate Past President – Patrice A. Harris.....Atlanta, Georgia
Secretary - Sandra Adamson Fryhofer.....Atlanta, Georgia
Speaker, House of Delegates - Bruce A. Scott.....Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert.....Kettering, Ohio

David H. Aizuss (2024).....Encino, California
Grayson W. Armstrong (2021).....Boston, Massachusetts
Willarda V. Edwards (2024).....Baltimore, Maryland
Jesse M. Ehrenfeld (2022).....Nashville, Tennessee
Scott Ferguson (2022).....West Memphis, Arkansas
Russell W.H. Kridel (2022), *Chair*.....Houston, Texas
Ilse R. Levin (2024).....Silver Spring, Maryland
Thomas J. Madejski (2024).....Medina, New York
Mario E. Motta (2022).....Salem, Massachusetts
Bobby Mukkamala (2021), *Chair-Elect*.....Flint, Michigan
Blake Elizabeth Murphy (2021).....Chicago, Illinois
Harris Pastides (2024).....Folly Beach, South Carolina
Jack S. Resneck, Jr (2022).....San Rafael, California
Michael Suk (2023).....Danville, Pennsylvania
Willie Underwood, III (2023).....Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Madelyn E. Butler, Tampa, Florida, Chair (2022); Pino D. Colone, Howell, Michigan, Vice Chair (2024); Ariel M. Anderson, New York, New York (Resident) (2021); Patricia L. Austin, Alamo, California (2022); Mark N. Bair, Highland, Utah (2023); Jerome C. Cohen, Loch Sheldrake, New York (2021); Anna S. Heffron, Madison, Wisconsin (Student) (2021); Kevin C. Reilly, Sr., Elizabethtown, Kentucky (2022).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Monique A. Spillman, Dallas, Texas, Chair (2021); Alexander M. Rosenau, Allentown, Pennsylvania, Vice Chair (2022); Rebecca W. Brendel, Boston, Massachusetts (2026); Kimberly A. Chernoby, Indianapolis, Indiana (Resident) (2021); David A. Fleming, Columbia, Missouri (2024); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Larry E. Reaves, Fort Worth, Texas (2027); Michael J. Rigby, Madison, Wisconsin (Student) (2021); Peter A. Schwartz, Reading, Pennsylvania (2023).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
Marilyn J. Heine, Dresher, Pennsylvania, Chair (2021); Mary S. Carpenter, Winner, South Dakota, Vice Chair (2021); Vijaya L. Appareddy, Chattanooga, Tennessee (2021); Hans C. Arora, Cleveland Heights, Ohio (Resident) (2021); Maryanne C. Bombaugh, Falmouth, Massachusetts (2021); Brooke M. Buckley, Bloomfield Hills, Michigan (AMPAC Liaison) (2022); Gary W. Floyd, Keller, Texas (2021); Ross F. Goldberg, Scottsdale, Arizona (2021); Drayton C. Harvey, Los Angeles, California (Student) (2021); Beth Irish, Bend, Oregon (Alliance Liaison) (2021); Tripti C. Kataria, Chicago, Illinois (2021); Heather Ann Smith, Newport, Rhode Island (2021); Ann Rosemarie Stroink, Bloomington, Illlinois (2021); Marta J. Van Beek, Iowa City, Iowa (2021).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Shannon Pryor, Chevy Chase, Maryland, Chair (2024); Clarence P. Chou, Milwaukee, Wisconsin, Vice Chair (2024); Michelle A. Berger, Austin, Texas (2022); Edmond B. Cabbabe, St. Louis, Missouri (2021); James A. Goodyear, Lansdale, Pennsylvania (2021); Priya S. Kantesaria, Somerset, New Jersey (Student) (2021); Jan M. Kief, Highlands Ranch, Colorado (2023); G. Sealy Massingill, Fort Worth, Texas (2023); Benjamin D. Meyer, Milwaukee, Wisconsin (Resident) (2022); Gary D. Thal, Chicago, Illinois (2021).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Liana Puscas, Durham, North Carolina, Chair (2021); Niranjan V. Rao, New Brunswick, New Jersey, Chair Elect (2022); Jacqueline A. Bello, New York, New York (2021); Kelly J. Caverzagie, Omaha, Nebraska (2023); Sharon P. Douglas, Madison, Mississippi (2023); Robert B. Goldberg, Morristown, New Jersey (2021); Cynthia A. Jumper, Lubbock, Texas (2024); Rohan Khazanchi, Omaha, Nebraska (Student) (2021); Shannon M. Kilgore, Palo Alto, California (2023); David J. Savage, La Jolla, California (Resident) (2023); Krystal L. Tomei, Cleveland, Ohio (2021); John P. Williams, Gibsonia, Pennsylvania (2023).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Lynda M. Young, Worcester, Massachusetts, Chair (2021); Asa C. Lockhart, Tyler, Texas, Chair-Elect (2022); A. Patrice Burgess, Boise, Idaho (2023); Steven L. Chen, San Diego, California (2024); Betty S. Chu, West Bloomfield, Michigan (2022); Alice Coombs, Richmond, Virginia (2023); Erick A. Eiting, New York, New York (2024); Stephen K. Epstein, Needham, Massachusetts (2022); Lynn L. C. Jeffers, Camarillo, California (2024); Neel R. Nabar, Philadelphia, Pennsylvania (Student) (2021); Sheila Rege, Kennewick, Washington (2022); Megan L. Srinavis, Fort Dodge, Iowa (Resident) (2023).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Kira A. Geraci-Ciardullo, Harrison, New York, Chair (2022); Alexander Ding, Belmont, California, Chair-Elect (2024); John T. Carlo, Dallas, Texas (2021); Noel N. Deep, Antigo, Wisconsin (2023); Laura E. Halpin, Los Angeles, California (Resident) (2022); Dayna J. Isaacs, Sacramento, California (Student); (2021); Mary E. LaPlante, Broadview Heights, Ohio (2021); Michael M. Miller, Madison, Wisconsin (2022); Tamaan K. Osbourne-Roberts, Denver, Colorado (2023); Padmini D. Ranasinghe, Baltimore, Maryland (2022); Corliss A. Varnum, Oswego, New York (2023); David J. Welsh, Batesville, Indiana (2024).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Stephen A. Imbeau, Florence, South Carolina, Chair; Brooke M. Buckley, Bloomfield Hills, Michigan, Secretary; Elie C. Azrak, St. Louis, Missouri; Paul J. Carniol, Summit, New Jersey; Ricardo Correa, Phoenix, Arizona; Hart L. Edmonson, Seattle, Washington (Student); Benjamin Z. Galper, Potomac, Maryland; Pratistha Koirala, New York, New York (Resident); James L. Milam, Libertyville, Illinois; L. Elizabeth Peterson, Spokane, Washington; Stephen J. Rockower, Rockville, Maryland; Janice Tildon-Burton, Wilmington, Delaware.
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

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

FORMER PRESIDENTS

David O. Barbe	2017-2018	Daniel H. Johnson, Jr.	1996-1997	William G. Plested, III	2006-2007
Lonnie R. Bristow	1995-1996	Jeremy A. Lazarus	2012-2013	Thomas R. Reardon	1999-2000
Peter W. Carmel	2011-2012	Robert E. McAfee	1994-1995	J. James Rohack	2009-2010
Yank D. Coble, Jr.	2002-2003	Barbara L. McAneny	2018-2019	Randolph D. Smoak, Jr.	2000-2001
Richard F. Corlin	2001-2002	Alan R. Nelson	1989-1990	Steven J. Stack	2015-2016
Nancy W. Dickey	1998-1999	John C. Nelson	2004-2005	Robert M. Wah	2014-2015
Andrew W. Gurman	2016-2017	Nancy H. Nielsen	2008-2009	Cecil B. Wilson	2010-2011
J. Edward Hill	2005-2006	Donald J. Palmisano	2003-2004	Percy Wootton	1997-1998
Ardis D. Hoven	2013-2014				

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Omar Z. Maniya	2016-2017
Susan Hershberg Adelman	1998-2002	Robert E. McAfee	1984-1993
Kendall S. Allred	2008-2009	Barbara L. McAneny	2010-2017
Raj S. Ambay	2009-2011	William A. McDade	2016-2020
Joseph P. Annis	2006-2014	Mary Anne McCaffree	2008-2016
John H. Armstrong	2002-2006	Joe T. McDonald	2005-2006
Maya A. Babu	2013-2017	Samuel J. Mackenzie	2014-2015
Timothy E. Baldwin	1987-1989	Robert R. McMillan	2002-2008
David O. Barbe	2009-2016	Sandeep “Sunny” Mistry	2000-2001
Regina M. Benjamin	1995-1998	Alan R. Nelson	1980-1988
Scott L. Bernstein	1991-1992	John C. Nelson	1994-2003
Stefano M. Bertozzi	1986-1988	Nancy H. Nielsen	2005-2007
David J. Brailer	1985-1986	Albert J. Osbahr, III	2011-2019
Lonnie R. Bristow	1985-1994	Donald J. Palmisano	1996-2002
Peter Carmel	2002-2010	Rebecca J. Patchin	1988-1989
Alice A. Chenault	1984-1985	Rebecca J. Patchin	2003-2011
Yank D. Coble	1994-2001	Stephen R. Permut	2010-2018
David S. Cockrum	1993-1994	Pamela Petersen-Crair	1996-1998
MaryAnn Contogiannis	1989-1993	Dina Marie Pitta	2015-2016
Malini Daniel	2012-2013	William G. Plested, III	1998-2005
Christopher M. DeRienzo	2006-2008	Stephen Pool	1995-1996
Nancy W. Dickey	1989-1997	Liana Puscas	1999-2001
Alexander Ding	2011-2013	Thomas R. Reardon	1990-1998
William A. Dolan	2007-2011	Kevin C. Reilly	2003-2005
Timothy T. Flaherty	1994-2003	Ryan J. Ribeira	2013-2014
Melissa J. Garretson	1992-1993	J. James Rohack	2001-2008
Michael S. Goldrich	1993-1997	David A. Rosman	2002-2004
Julie K. Goonewardene	2012-2016	Samantha L. Rosman	2005-2009
Andrew W. Gurman	2007-2015	Raymond Scalettar	1985-1994
Alan C. Hartford	1989-1990	Bruce A. Scott	1998-2002
William A. Hazel, Jr	2004-2009	Carl A. Sirio	2010-2018
Cyril M. Hetsko	2003-2011	Sarah Mae Smith	2019-2020
Joseph M. Heyman	2002-2010	Randolph D. Smoak, Jr.	1992-1999
J. Edward Hill	1996-2004	Steven J. Stack	2006-2014
Ardis D. Hoven	2005-2012	Michael Suk	1994-1995
William E. Jacott	1989-1998	Andrew M. Thomas	1997-1999
Hillary D. Johnson	2001-2002	Jeffrey A. Towson	1998-1999
Matthew D. Kagan	1999-2000	Georgia A. Tuttle	2011-2019
Christopher K. Kay	2008-2012	Jordan M. VanLare	2011-2012
William E. Kobler	2012-2020	Robert M. Wah	2005-2013
Edward L. Langston	2003-2011	Peter Y. Watson	2001-2003
Matthew C. Lawyer	2004-2005	Monica C. Wehby	2011-2013
Jeremy A. Lazarus	2005-2011	Kevin W. Williams	2016-2020
W. J. Lewis	1979-1984	Meredith C. Williams	2010-2011
Audrey J. Ludwig	1990-1991	Cecil B. Wilson	2002-2009
Justin B. Mahida	2009-2010	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

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

American Academy of Emergency Medicine ..... Joseph Wood, MD, JD
American Association of Endocrine Surgeons ..... Dina Elaraj, MD
American Association of Hip and Knee Surgeons ..... Beau Kildow, MD
American College of Correctional Physicians ..... Charles Lee, MD
American Contact Dermatitis Society ..... Bruce Brod, MD
American Epilepsy Society ..... David M. Labiner, MD
American Society for Laser Medicine and Surgery ..... George Hruza, MD
American Society of Regional Anesthesia and Pain Medicine ..... David Provenzano, MD
Americas Hernia Society ..... John Fischer, MD
Association of Academic Physiatrists ..... Prakash Jayabalan, MD, PhD
Association of Professors of Dermatology ..... Christopher R. Shea, MD
Korean American Medical Association ..... John Yun, MD
Outpatient Endovascular and Interventional Society ..... Eric Dippel, MD
Society of Gynecologic Oncologists ..... S. Diane Yamada, MD
American Academy of Addiction Psychiatry ..... Alena Balasanova, MD
Society for Cardiovascular Magnetic Resonance ..... Edward T. Martin, MD

MEMBERS OF THE HOUSE OF DELEGATES SPECIAL MEETING - JUNE 2021
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)

Jorge Alsip, Daphne AL

Steven P. Furr, Jackson AL

B Jerry Harrison, Haleyville AL

George C. Smith Jr, Lineville AL

Alternate Delegate(s)

Harry Kuberg, Russelville AL

Alexis Mason, Tuscaloosa AL

John Meigs Jr, Brent AL

William Schneider, Huntsville AL

Regional Medical Student Alternate Delegate(s)

Megan Ward, Murfreesboro TN

Alaska State Medical Association

Delegate(s)

Alex Malter, Juneau AK

Alternate Delegate(s)

Mary Ann Foland, Anchorage AK

Arizona Medical Association

Delegate(s)

Daniel P. Aspery, Phoenix AZ

Veronica K. Dowling, Lakeside AZ

Gary R. Figge, Tucson AZ

Michael Hamant, Tucson AZ

M Zuhdi Jasser, Phoenix AZ

Alternate Delegate(s)

Timothy Fagan, Tucson AZ

Ross F. Goldberg, Scottsdale AZ

Jennifer Hartmark-Hill, Phoenix AZ

Jacquelyn Hoffman, Tucson AZ

Arizona Medical Association

Alternate Delegate(s)

Marc Leib, Phoenix AZ

Regional Medical Student Delegate(s)

Meera Kapadia, Chandler AZ

Regional Medical Student Alternate Delegate(s)

Avi Levy, Paradise Vly AZ

California Medical Association

Delegate(s)

Jerry P Abraham, Los Angeles CA

Barbara J. Arnold, Sacramento CA

Patricia L. Austin, Alamo CA

Dirk Stephen Baumann, Burlingame CA

Jeffrey Brackett, Ventura CA

Peter N. Bretan Jr, Novato CA

Jacob Burns, Sacramento CA

J Brennan Cassidy, Newport Beach CA

Luther Cobb, Eureka CA

Maisha Draves, Fairfield CA

Kyle P. Edmonds, San Diego CA

Rachel Ekaireb, Sacramento CA

George Fouras, Los Angeles CA

Dev A. GnanaDev, Redlands CA

James T. Hay, Del Mar CA

Robert Hertzka, Rancho Santa Fe CA

Samuel Huang, Los Angeles CA

Vito Imbasciani, Los Angeles CA

Melissa Jones, Sacramento CA

Kermit Jones, Vacaville CA

Kim Lau, Davis CA

California Medical Association

Delegate(s)

Edward Lee, Sacramento CA

Arthur N. Lurvey, Los Angeles CA

Michael Luszczak, Carmichael CA

Ramin Manshadi, Stockton CA

Robert J. Margolin, San Francisco CA

Theodore Mazer, San Diego CA

Kelly McCue, Davis CA

Stephen Parodi, Oakland CA

Albert Ray, San Diego CA

Tatiana W. Spirtos, Redwood City CA

Holly Yang, San Diego CA

Paul Yost, Seal Beach CA

Alternate Delegate(s)

Raag Agrawal, Los Angeles CA

Alan Anzai, Sacramento CA

David Bazzo, San Diego CA

Lawrence Cheung, San Francisco CA

Jack Chou, Baldwin Park CA

James Cotter, Napa CA

Alexander Ding, Louisville KY

Suparna Dutta, CA

David Friscia, San Diego CA

Anjalee Galion, Santa Ana CA

Jennifer Hone, Santa Barbara CA

Scott Richard Karlan, West Hollywood CA

Nikan Khatibi, Laguna Niguel CA

Jeff Klingman, Orinda CA

Mark H. Kogan, San Pablo CA

Man Kit Leung, San Francisco CA

Ashley McClure, Oakland CA

California Medical Association

Alternate Delegate(s)

Sandra Mendez, Sacramento CA

Chang Na, Bakersfield CA

Richard Pan, Sacramento CA

Bing Pao, Escondido CA

Mihir Parikh, La Jolla CA

Damodara Rajasekhar, Apple Valley CA

Ryan J. Ribeira, Mountain View CA

Sion Roy, Torrance CA

Ashley Rubin, Sacramento CA

Rodolfo Saenz, Riverside CA

Lorin Scher, Sacramento CA

Seema Sidhu, Fremont CA

Sarah M. Smith, Anaheim CA

James J. Strebig, Irvine CA

Raymond Tsai, Lost Hills CA

Barbara Weissman, Pacifica CA

Resident and Fellow Sectional Delegate(s)

Daniel Udrea, Loma Linda CA

Sophia Yang, San Jose CA

Regional Medical Student Delegate(s)

Russyan Mark Mabeza, Los Angeles CA

Regional Medical Student Alternate Delegate(s)

Vinita Shivakumar, Stanford CA

Colorado Medical Society

Delegate(s)

David Downs, Denver CO

Jan Kief, Merritt Island FL

A. "Lee" Morgan, Denver CO

Tamaan Osbourne-Roberts, Denver CO

Lynn Parry, Littleton CO

Current as of: 5/4/2021

Colorado Medical Society

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO

Rachelle M. Klammer, Denver CO

Katie Lozano, Centennial CO

Brigitta J. Robinson, Centennial CO

Michael Volz, Englewood CO

Regional Medical Student Delegate(s)

Alysa Edwards, Colorado Springs CO

Connecticut State Medical Society

Delegate(s)

Michael L. Carius, Stratford CT

Katherine L. Harvey, CT

Bollepalli Subbarao, Middletown CT

Theodore Zanker, Cheshire CT

Alternate Delegate(s)

Kathleen A. LaVorgna, Norwalk CT

Gwendolyn Moraski, West Simsbury CT

Stacy Taylor, New Hartford CT

Steven C. Thornquist, Bethany CT

Resident and Fellow Sectional Delegate(s)

Pratistha Koirala, Danbury CT

Regional Medical Student Delegate(s)

Ryan Englander, Farmington CT

Regional Medical Student Alternate Delegate(s)

Ian Whittall, Farmington CT

Annie Yao, Farmington CT

Medical Society of Delaware

Delegate(s)

Janice Tildon-Burton, Wilmington DE

Alternate Delegate(s)

Stephanie Howe Guarino, Wilmington DE

Medical Society of the District of Columbia

Delegate(s)

Peter E. Lavine, Washington DC

J Desiree Pineda, Potomac MD

Raymond K. Tu, Washington DC

Alternate Delegate(s)

Neal D Barnard, Washington DC

E W Emanuel, Washington DC

Regional Medical Student Alternate Delegate(s)

Naeha Haridasa, Arlington VA

Florida Medical Association

Delegate(s)

Christie P. Alexander, Tallahassee FL

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June 2021 Special Meeting

Note on Order of Business
(All Times are Central Standard Time)

FIRST SESSION, Friday, June 11, 7:00 – 9:00 pm

SECOND SESSION, Monday, June 14, 10:00 am – 6:00 pm

THIRD SESSION, Tuesday, June 15

- Election Session 9:00 – 10:00 am
- HOD 10:00 am – 5:00 pm

FOURTH SESSION, Wednesday, June 16, 9:00 am - adjourn

Reference Committee Hearing Schedule
June 2021 Special Meeting

The final schedule for reference committee hearings follows (all times based on Chicago and Central Daylight Time):

Saturday, June 12, 9 am to 12:30 pm

- Reference Committee A
- Reference Committee E
- Reference Committee F

Saturday, June 12, 1 pm to 4:30 pm

- Reference Committee B
- Reference Committee D
- Reference Committee G

Sunday, June 13, 9 am to 12:30 pm

- Reference Committee on Amendments to Constitution & Bylaws
- Reference Committee C

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES
(June 2021 Special Meeting)

Reference Committee on Amendments to Constitution and Bylaws
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Michael Hanak, MD, American Academy of Family Physicians
George Hruza, MD, Missouri
Lee S. Perrin, MD, Massachusetts
John W. Poole, MD, New Jersey
Tatiana (Tanya) W. Spirtos, MD, California
L. Carlos Zapata, MD, New York

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Andrea Hillerud, MD, Minnesota
Dale Mandel, MD, Pennsylvania
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Vinita Shivakumar, California, Regional Medical Student

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Tina Shah, MD, Society of Critical Care Medicine

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Mark Milstein, MD, American Academy of Neurology
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David J. Bensema, MD, Kentucky
Veronica K. Dowling, MD, Arizona
Cheryl Gibson Fountain, MD, American College of Obstetricians and Gynecologists
Stuart J. Glassman, MD, MBA, American Academy of Physical Medicine and Rehabilitation
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Reference Committee G (Medical Practice)
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Ronald F. Giffler, MD, Florida
Rachelle Klammer, MD, Colorado
Alma B. Littles, MD, Academic Physicians Section
Parag Mehta, MD, New York
Peter S. Rahko, MD, American Society of Echocardiography

Committee on Rules and Credentials
Tripti C. Kataria, MD, American Society of Anesthesiologists
Emily Briggs, MD, American Academy of Family Physicians
Elisa Choi, MD, American College of Physicians
Loralie D. Ma, MD, MD
Joshua M. V. Mammen, MD, International College of Surgeons - US Section
Joseph Sanfrancesco, MD College of American Pathologists
Kenath Shamir, MD, MA

SUMMARY OF FISCAL NOTES (JUNE 2021)

BOT Report(s)

01 Annual Report: None
02 2020 Grants and Donations: Informational report
03 AMA 2022 Dues: No significant fiscal impact
04 Update on Corporate Relationships: Informational report
05 AMA Performance, Activities and Status in 2020: Informational report
06 Annual Update on Activities and Progress in Tobacco Control: March 2020 Through February 2021: Informational report
07 Council on Legislation Sunset Review of 2011 House Policies: Minimal
08 Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report): Informational report
09 Preservation of the Patient-Physician Relationship: None
10 Protestor Protections: Minimal
11 Redefining the AMA's Position on ACA and Healthcare Reform: Informational report
12 Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment: Modest
13 Amending the AMA's Medical Staff Rights and Responsibilities: Minimal
14 Pharmaceutical Advertising in Electronic Health Record Systems: Minimal
15 Removing Sex Designation from the Public Portion of the Birth Certificate: Minimal
16 Follow-up on Abnormal Medical Test Findings: Minimal
17* Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal
18* Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19: Minimal

CC&B Report(s)

01* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs: Minimal
02* AMA Women Physicians Section: Clarification of Bylaw Language: Minimal
03* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section): Minimal

CEJA Opinion(s)

01* Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients: Informational Report
02* Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians": Informational Report

CEJA Report(s)

01* CEJA's Sunset Review of 2011 House Policies: Minimal
02* Short-term Medical Service Trips: Minimal
03* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues": Minimal
04* Augmented Intelligence & the Ethics of Innovation in Medicine: Informational Report
05* Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report: Informational Report

CLRPD Report(s)

01* Demographic Characteristics of the House of Delegates and AMA Leadership: Informational Report

CME Report(s)

01* Council on Medical Education Sunset Review of 2011 House Policies: Minimal
02* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses: Minimal

SUMMARY OF FISCAL NOTES (JUNE 2021)

CME Report(s)

03* Optimizing Match Outcomes: Minimal
04* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice: Minimal
05* Promising Practices Among Pathway Programs to Increase Diversity in Medicine: Modest

CMS Report(s)

01* Council on Medical Service's Sunset Review of 2011 House Policies: Minimal
02* Continuity of Care for Patients Discharged from Hospital Settings: Minimal
03* Universal Basic Income Pilot Studies: Minimal
04* Promoting Accountability in Prior Authorization: Minimal
05* Medical Center Patient Transfer Policies: Minimal
06* Urgent Care Centers: Minimal
07* Addressing Equity in Telehealth: Minimal
08* Licensure and Telehealth: Modest
09* Addressing Payment in Delivery in Rural Hospitals: Minimal

CSAPH Report(s)

01* Council on Science and Public Health Sunset Review of 2011 House Policies: Minimal
02* Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings: Minimal
03* Addressing Increases in Youth Suicide: Minimal

Joint Report(s)

01* CCB/CLRPD Joint Council Sunset Review of 2011 House Policies: Minimal

Report of the Speakers

01 Recommendations for Policy Reconciliation: Informational report
02 Report of the Election Task Force: Up to $250,000 if AMA elects to sponsor a reception, depending on the number of people and food and beverage.

Resolution(s)

001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD): Modest
002 Sharing Covid-19 Resources: Modest
003* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions: Minimal
004* AMA Resident/Fellow Councilor Term Limits: Minimal
005* Resident and Fellow Access to Fertility Preservation: Modest
006* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients: Modest
007* Nonconsensual Audio/Video Recording at Medical Encounters: Minimal
008* Organ Transplant Equity for Persons with Disabilities: Modest
009* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties: Moderate
010* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses: Minimal
011* Truth, Reconciliation and Healing in Medicine and Medical Education: not yet determined
012* Increasing Public Umbilical Cord Blood Donations in Transplant Centers: Modest
013* Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

014* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Moderate

015* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals: Minimal

016* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal

017* Improving the Health and Safety of Sex Workers: Minimal

018* LGBTQ+ Representation in Medicine: Moderate

019* Evaluating Scientific Journal Articles for Racial and Ethnic Bias: Modest

020* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954: Minimal

021* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions: Minimal

101 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits: Modest

102 Bundling Physician Fees with Hospital Fees: Minimal

103 COBRA for College Students: Modest

104 Medicaid Tax Benefits: Modest

105 Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums: Estimated cost of $260,000. The specific action planned if adopted would be to hire a research/consulting firm to develop different scenarios based on a range of utilization changes (e.g., what is new, and what is just a shift from in-person) and downstream effects

106 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?: Modest

107* Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance: Minimal

108* Implant Associated Anaplastic Large Cell Lymphoma: Minimal

109* Support for Universal Internet Access: Modest

110* Healthcare Marketplace Plan Selection: Modest

111* Towards Prevention of Hearing-Loss Associated Cognitive Impairment: Modest

112* Fertility Preservation Benefits for Active-Duty Military Personnel: Modest

113* Support for Universal Internet Access: Modest

114* Reimbursement of School-Based Health Centers: Minimal

115* Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration: Modest

116* Caps on Insulin Co-Payments for Patients with Insurance: Minimal

117* Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System: Modest

201 Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication: Modest

202 Prohibit Ghost Guns: Minimal

203 Ban the Gay/Trans (LGBTQ+) Panic Defense: Modest

204 Insurers and Vertical Integration: Modest

205 Protection of Peer-Review Process: Modest

206* Redefining the Definition of Harm: Modest

207* Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education: Estimated cost of $100,000 for staff expenses and consultant fees.

208* Increasing Residency Positions for Primary Care: Modest

209* Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research: Modest

210* Ransomware and Electronic Health Records: Modest

211* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients: Modest

212* ONC's Information Blocking Regulations: Modest

213* CMMI Payment Reform Models: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

214* Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities: Minimal
215* Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs: Minimal
216* Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies: Minimal
217* Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19: Minimal
218* Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity: Modest
219* Oppose Tracking of People who Purchase Naloxone: Minimal
220* Equal Access to Adoption for the LGBTQ Community: Minimal
221* Support for Mental Health Courts: Minimal
222* Advocating for the Amendment of Chronic Nuisance Ordinances: Minimal
223* Supporting Collection of Data on Medical Repatriation: Modest
224* Using X-Ray and Dental Records for Assessing Immigrant Age: Minimal
301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic: Modest
302 Non-Physician Post-Graduate Medical Training: Modest
303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE: Modest
304* Decreasing Financial Burdens on Residents and Fellows: Minimal
305* Non-Physician Post-Graduate Medical Training: Modest
306* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training: Minimal
307* Updating Current Wellness Policies and Improving Implementation: Minimal
308* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure: Minimal
309* Supporting GME Program Child Care Residency Training: Modest
310* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine: Minimal
311* Student Loan Forgiveness: Modest
312* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs: Minimal
313* Fatigue Mitigation Respite for Faculty and Residents: Minimal
314* Standard Procedure for Accommodations in USMLE and NBME Exams: Modest
315* Representation of Dermatological Pathologies in Varying Skin Tones: Minimal
316* Improving Support and Access for Medical Students with Disabilities: Modest
401 Universal Access for Essential Public Health Services: Modest
402 Modernization and Standardization of Public Health Surveillance Systems: Modest
403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America: not yet determined
404* Support for Safe and Equitable Access to Voting: Minimal
405* Traumatic Brain Injury and Access to Firearms: Modest
406* Attacking Disparities in Covid-19 Underlying Health Conditions: Minimal
407* Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities: Modest
408* Screening for HPV-Related Anal Cancer: Minimal
409* Weapons in Correctional Healthcare Settings: not yet determined
410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis: not yet determined
411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens: not yet determined

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

412* Addressing Maternal Discrimination and Support for Flexible Family Leave: Minimal
413* Call for Increased Funding and Research for Post Viral Syndromes: not yet determined
414* Call for Improved Personal Protective Equipment Design and Fitting: not yet determined
415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles: Modest
416* Expansion on Comprehensive Sexual Health Education: not yet determined
417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925: Minimal
418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV: not yet determined
419* Student-Centered Approaches for Reforming School Disciplinary Policies: not yet determined
501 Ensuring Correct Drug Dispensing: Minimal
502 Scientific Studies Which Support Legislative Agendas: Minimal
503 Access to Evidence-Based Addiction Treatment in Correctional Facilities: Minimal
504* Healthy Air Quality: Minimal
505* Personal Care Product Safety: Modest
506* Wireless Devices and Cell Tower Health and Safety: Minimal
507* Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues: Minimal
601* $100 Member Annual Dues Payment Through 2023: Cost to implement this resolution of $20.9 million annually.
602* Timely Promotion and Assistance in Advance Care Planning and Advance Directives: Moderate
603* AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels: Moderate
604* Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis: not yet determined
605* Amending G-630.140, Lodging, Meeting Venues and Social Functions: Minimal
606* AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations: Minimal
701 Physician Burnout is an OSHA Issue: Modest
702 Addressing Inflammatory and Untruthful Online Ratings: Minimal
703 Employed Physician Contracts: Minimal
704 Eliminating Claims Data for Measuring Physician and Hospital Quality: Modest
705* Improving the Prior Authorization Process: Modest
706* Prevent Medicare Advantage Plans from Limiting Care: Modest
707* Financial Incentives for Patients to Switch Treatments: Modest
708* Medicare Advantage Record Requests: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

17* Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)

01* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs

02* AMA Women Physicians Section: Clarification of Bylaw Language

03* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)

CEJA Report(s)

01* CEJA's Sunset Review of 2011 House Policies

02* Short-term Medical Service Trips

03* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"

Report of the Speakers

02 Report of the Election Task Force

Resolution(s)

001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD)

002 Sharing Covid-19 Resources

003* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions

004* AMA Resident/Fellow Councilor Term Limits

005* Resident and Fellow Access to Fertility Preservation

006* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients

007* Nonconsensual Audio/Video Recording at Medical Encounters

008* Organ Transplant Equity for Persons with Disabilities

009* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties

010* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses

011* Truth, Reconciliation and Healing in Medicine and Medical Education

012* Increasing Public Umbilical Cord Blood Donations in Transplant Centers

013* Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism

014* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

015* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals

016* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

017* Improving the Health and Safety of Sex Workers

018* LGBTQ+ Representation in Medicine

019* Evaluating Scientific Journal Articles for Racial and Ethnic Bias

020* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954

021* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-JUN-21

Subject: Specialty Society Representation in the House of Delegates - Five-Year Review

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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The Board of Trustees (BOT) has completed its review of the specialty organizations and the professional interest medical association seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2021 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," Policy G-600.022 "Admission of Professional Interest Medical Associations to our AMA House" and AMA Bylaw 8.5, "Periodic Review Process." Although the 2021 Annual Meeting has been suspended by action of the Board of Trustees, to maintain a consistent review process the Board completed this review to be presented at the June 2021 Special Meeting of the House of Delegates.

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of national medical specialty organizations and professional interest medical associations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2021 Special Meeting:

AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Child and Adolescent Psychiatry
American Association of Clinical Endocrinology
American Association of Physicians of Indian Origin
American College of Medical Genetics and Genomics
American College of Radiation Oncology
American Institute of Ultrasound in Medicine
American Orthopaedic Foot and Ankle Society
American Society for Clinical Pathology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Dermatopathology
American Society of Neuroradiology
Obesity Medicine Association
Renal Physicians Association
Society of Critical Care Medicine
Society of Interventional Radiology

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Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society and professional medical interest association representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations and profession interest medical associations represented in the HOD.

RECOMMENDATIONS

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

1. That AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

Fiscal Note: Less than $500

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APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
AMDA – The Society for Post-Acute and Long-Term Care Medicine	564 of 2,561 (22%)
American Academy of Child and Adolescent Psychiatry	1,186 of 7,033 (17%)
American Association of Clinical Endocrinology	541 of 2,547 (21%)
American Association of Physicians of Indian Origin	1,687 of 12,049 (14%)
American College of Medical Genetics and Genomics	339 of 687 (49%)
American College of Radiation Oncology	267 of 724 (37%)
American Institute of Ultrasound in Medicine	918 of 4,406 (20%)
American Orthopaedic Foot and Ankle Society	212 of 889 (24%)
American Society for Clinical Pathology	1,948 of 7,584 (26%)
American Society of Anesthesiologists	7,001 of 44,293 (16%)
American Society of Cataract and Refractive Surgery	1,013 of 4,088 (25%)
American Society of Colon and Rectal Surgeons	685 of 2,738 (25%)
American Society of Dermatopathology	336 of 1,124 (30%)
American Society of Neuroradiology	1,017 of 4,771 (21%)
Obesity Medicine Association	402 of 1,959 (20%)
Renal Physicians Association	481 of 2,078 (23%)
Society of Critical Care Medicine	1,404 of 6,918 (20%)
Society of Interventional Radiology	679 of 3,271 (21%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies and Professional Interest Medical Associations (Policies G-600.020 and G-600.022)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

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

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

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

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

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

6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.

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

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

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

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

G-600.022

Professional Interest Medical Associations (PIMAs) are organizations that relate to physicians along dimensions that are primarily ethnic, cultural, demographic, minority, etc., and are neither state associations nor specialty societies. The following guidelines will be utilized in evaluating PIMA applications for representation in our AMA House of Delegates (new applications will be considered only at Annual Meetings of the House of Delegates):

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA.

2. The organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association).

3. The organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA.

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

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

6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.

7. The organization must be active within the profession and hold at least one meeting of its members per year.

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

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

10. If international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

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

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5. If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-JUN-21

Subject:	Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs
Presented by:	Madelyn E. Butler, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

During 2020, the five-year transition from dual accreditation entities acknowledged in the AMA Bylaws (ACGME for allopathic physicians and AOA for osteopathic physicians) to a single accreditation entity for all was completed. The ACGME now serves as the nation's sole accreditor for both osteopathic (DO) and allopathic (MD) residencies and fellowships.

The Council has prepared this report with appropriate bylaw amendments to ensure that the AMA Constitution and Bylaws remains an accurate document.

RECOMMENDATIONS

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.

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education ~~or the American Osteopathic Association~~.
b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

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a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education ~~or the American Osteopathic Association~~.
b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

(Modify Bylaws)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-JUN-21

Subject: AMA Women Physicians Section: Clarification of Bylaw Language

Presented by: Madelyn E. Butler, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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In 2013, the Board of Trustees Women Physicians Advisory Committee transitioned to the Women Physicians Section (WPS). The Council has worked closely with the WPS since its inception and developed the existing bylaw language. The Council also has reviewed several iterations of the WPS Internal Operating Procedures that were approved by the Board in 2013 and in 2017.

The IOP states that "all female physician and medical student members of the AMA as identified in the AMA Masterfile are automatically enrolled in the WPS." The IOP further provides the opportunity for any other AMA member to opt-in as a WPS member. However, AMA Bylaw 7.10.1, states that "all female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section." Per Bylaw 7.10.11, "Other active AMA members who express an interest in women's issues shall be eligible for WPS membership." The subtle distinction is that according to the Bylaws, all AMA member female physicians and students are "eligible" to join, whereas the IOP includes them "automatically". The WPS Governing Council has asked the Council to consider proposing changes to Bylaw 7.10.1.

The WPS believes the IOP language better reflects the intent of the House when it created the section and supports the existing practice of automatically enrolling all AMA member female physicians as WPS members. The Council on Constitution and Bylaws concurs and presents this report for House action.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA 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.

7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.

7.10.1 Membership. All female physicians and medical students who are active members of the AMA shall be ~~eligible to be~~ members of the Women Physicians Section. ~~**7.10.1.1**~~ Other active members of the AMA who express an interest in women's issues shall be eligible to join the section. (Modify Bylaws)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-JUN-21

Subject:	Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)
Presented by:	Madelyn E. Butler, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

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The suspension of the 2020 Annual Meeting led to questions about eligibility for election within the Young Physicians Section, and the Council on Ethical and Judicial Affairs suggested that the Council on Constitution and Bylaws clarify the language of Bylaw 7.5.2 to more clearly explain when a YPS governing council member's eligibility to remain in office. Per Bylaw 6.5.2.2, CEJA has responsibility for interpreting the Constitution, Bylaws and rules of the AMA.

Bylaw 7.5.2 states: "If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If any officer's or member's term would terminate prior to the conclusion of an Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA. The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA."

Bylaw 7.5.1, defines YPS Membership as "All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs."

In preparing this report, the Council stresses that its intent is to clarify existing language consistent with prior House action.

BACKGROUND

When the Young Physicians Section was established in 1986, YPS membership was defined as physicians under the age of 40 or within the first five years of professional practice. The Bylaws at that time stated that any physician who met the criteria for section membership was eligible to run for office but would need to resign if for any reason the individual ceased to be a member of the section. An additional provision provided specificity about how the chair-elect served a one-year term, then automatically assumed the chair position for another year and ultimately moved into the immediate past chair position for a total of 3 years of service. At all times, that individual was required to meet the definition of young physician.

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Over the ensuing years, the House adopted several bylaw amendments, notably:

- Language allowing the immediate past chair to serve even if he/she no longer is considered a young physician [CCB Report E, A-92]

- A grace period for governing council members (except the chair-elect) whose eligibility for YPS membership ends in the months preceding an Annual Meeting [CCB Report 4, I-03]

- Redefining a young physician as under age 40 or within the first 8 years of professional practice [CCB Report 2, A-07]

DISCUSSION

The current language of 7.5.2 dates from 1992 and is a bit confusing as it pertains to who can run for and hold the positions of chair-elect, chair and immediate past chair, which is what brought the issue to CEJA's attention.

Historical bylaw language stating that the chair-elect to immediate past chair progression entailed a total of 3 years of service was eliminated in 2006 when the Bylaws were simplified by consolidating many provisions and removing others from the Bylaws into individual section internal operating procedures [CCB Report 2, A-06]. Initially, the physician elected to the chair-elect position was required to meet the definition of 'young physician' for the entire 3-year term. Over time, the House provided an exemption for any chair (or other governing council member with the exception of the chair-elect) who reached the age of 40 or the maximum years in practice in the calendar year in which YPS elections occur to serve out the term. The House later added an additional grace provision to allow an immediate past chair to fulfill the 3-year commitment despite attaining age 40 or reaching the maximum years in practice.

Current Bylaw 7.5.2 as written and taken in accord with other bylaw language, which stipulates that all governing council members must be eligible for YPS section membership, prohibits a young physician from running for the chair-elect position if that individual will "age" or "term out" at any time during a chair-elect year, hence the wording "The preceding provision shall not apply to the Char-Elect." Other language ("If any officer's … term would terminate prior to the conclusion of an Annual Meeting, such officer … shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1…" allows the chair to serve a full year as YPS chair if the birthday or time in practice component of the eligibility criteria occurs between January and June. If, however, the birthday or years in practice occurs between June and year-end, the individual is not allowed to complete the term and must vacate the office. All chairs who complete the chair term may progress to the immediate past chair position regardless of age or time in practice, thus the language "Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA."

Several other bylaws impact the language of 7.5.2:

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. The programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section.

7.0.4 Officers. Each Section shall select a Chair and Vice Chair or Chair-Elect and other necessary and appropriate officers.

7.0.4.1 Qualifications. Officers of each Section must be members of the AMA and of the Section.

As requested by CEJA, the Council has developed the following amended bylaw language which it believes more clearly states the requirements:

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

RECOMMENDATIONS

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.

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

7.5.2 Cessation of Eligibility <u>of Governing Council Members</u>. If any ~~officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw

7.5.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant. If any ~~officer's or~~ member's term would terminate prior to the conclusion of an Annual Meeting, such ~~officer or~~ member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such ~~officer or~~ member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the ~~officer or~~ member remains an active physician member of the AMA. ~~The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA.~~

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

(Modify Bylaws)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-JUN-21

Subject: CEJA's Sunset Review of 2011 House Policies

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

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

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

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

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

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

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

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

RECOMMENDATION

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

Fiscal Note: Less than $500.

APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-140.980	Pending Federal Executions	Our AMA immediately inquire whether federal executions involve physicians, and if physicians are involved, that our AMA communicate to the federal government that such physician participation violates fundamental ethical standards of the medical profession and that other appropriate means be substituted that do not require physician participation. (Res. 9, A-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; still relevant but superseded by more recent policy: H-140.898 Medical Profession Opposition to Physician Participation in Execution; 9.7.3 Capital Punishment Code of Medical Ethics; D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols; H-140.963 Secrecy and Physician Participation in State Executions
D-315.988	Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry	Our AMA will (1) work to control the use of physician-specific prescribing data by the pharmaceutical industry as follows: (a) implement a suitable "opt-out" mechanism for the AMA Physician Masterfile governing the release of physician-specific prescribing data to pharmaceutical sales reps by including appropriate restrictions in the AMA data licensing agreements; (b) communicate to physicians the resources available to them in reporting inappropriate behavior on the part of pharmaceutical sales representatives and the work the AMA has done and will continue to do on their behalf; and (c) work with Health Information Organizations (HIOs) to describe to physicians how their prescribing data are used and work to create access for physicians to view reports on their own prescribing data to enhance their clinical practice; and (2) ~~assume a leadership position in both developing a~~ Support continued updating of Prescribing Data Code of Conduct for the Pharmaceutical Industry that dictates appropriate use of pharmaceutical data, behavior expectations on the part of industry, and consequences of misuse or misconduct~~, and in convening representatives from HIOs and the pharmaceutical companies to promulgate the adoption of the code of conduct in the use of prescribing data~~. (BOT Rep. 24, I-04; Reaffirmed in lieu of Res. 624, A-05; Reaffirmation A-09; Reaffirmed: Res. 233, A-11)	Rescind in part. (1) Remains relevant (2) Remains relevant, though a guide for interaction has been developed (can be found here). Language amended as shown to reflect continued support of guidance.

D-350.991	Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities	Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities. (Res. 409, A-09; Appended: Res. 416, A-11)	Rescind in light of the dissolution of the Commission to End Health Care Disparities; initiatives of the newly launched Center for Health Equity, and; superseded by policies adopted in 2019 and 2020: H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice; D-350.981 Racial Essentialism in Medicine; H-65.952 Racism as a Public Health Threat; H-350.974 Racial and Ethnic Disparities in Health Care
D-435.995	Medical Care Online	Our AMA will educate physicians to be aware of clauses in their professional liability insurance coverage which may require them to report changes or additions to their practice-related activities, including the use or sponsorship of Web sites, e-mail, Internet discussion groups, and mailing lists. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant.
H-120.991	Sample Medications	Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge; (2) reiterates that samples of prescription drug products represent valuable benefits to the patients; (3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and (4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription	Retain; remains relevant

		drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples. (Sub. Res. 17, I-86; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: Res. 516, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-140.850	Exhibition of Plasticized Bodies Without Known Informed Consent	Our AMA will request that the United States or international authorities investigate if the bodies for the Premier Exhibition Inc. "Bodies Revealed" exhibits were obtained according to international human rights norms. (Res. 7, A-11)	Rescind; accomplished. Per June 2012 Implementation Chart: A letter signed by Dr. Madara was sent on September 22, 2011 requesting the Department of State - Bureau of Democracy, Human Rights, and Labor to participate in a thorough investigation of the manner in which plasticized remains have been obtained to assure that international human rights norms, including informed consent for the donation, have been followed.
H-140.901	Equity in Health Care for Domestic Partnerships	Our AMA supports legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision maker in the absence of an alternative health care proxy designee. (Res. 101, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant.
H-140.964	Enforcement of Code of Ethics	It is the policy of the AMA (1) to make appropriate education and enforcement of its ethical guidelines a priority and (2) with the input and consent of the Federation, to begin a process to coordinate the Federation, including specialty societies and hospital medical staffs, in joint efforts to better communicate and enforce ethical standards. (BOT Rep. BBB, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-140.967	Conflicts of Interest	Our AMA calls on state and county medical societies to seek out and to respond to complaints of significant violations of the Council on Ethical and Judicial Affairs' guidelines, and it reminds those societies of the AMA's pledge to stand behind and to provide financial support for any society enforcing in good faith and under approved disciplinary procedures AMA's code of	Retain; remains relevant.

		ethics. (CEJA Rep. G, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	
H-245.969	Opposing Legal Prohibition of Circumcision	Our AMA will oppose any attempt to legally prohibit male infant circumcision. (Res. 222, I-11)	Rescind; more recent policy better captures the nuances of supporting male infant circumcision: H-60.945 Neonatal Male Circumcision, which reads: 1. Our AMA: (a) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (b) supports the general principles of the 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." and (c) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions. 2. Our AMA encourages state

			Medicaid reimbursement of neonatal male circumcision.
H-275.976	Boundaries of Practice for Health Professionals	~~(1)~~ The health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services required by an individual patient are provided by a professional whose basic competence and current performance are suited to render those services safely and effectively. In addition, patients also have a responsibility for maintaining coordination and continuity of their own health care. ~~(2) As a supplement to strengthen state licensure of health professionals, standard-setting and self-regulatory competency assurance programs should be conducted by health professions associations, certifying and accrediting agencies, and health care facilities~~. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 8, A-11)	Retain in part. Retain (1); remains relevant. Rescind (2); superseded by more recent policy H-300.982 Maintaining Competence of Health Professionals, which reads in part: (1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such

			standards should be reviewed and revised periodically.
H-285.910	The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community	Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services: **Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community** In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph. (Res. 8, A-11)	Retain; remains relevant.
H-350.972	Improving the Health of Black and Minority Populations	Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early	Retain; remains relevant.

		diagnosis. (CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)	
H-375.984	Participation in Peer Review	Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer review should address the prevention of medical errors and appropriate system changes. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: BOT Rep. 13, I-11)	Retain; remains relevant. Title amended for clarity of content.
H-375.989	Protection of Peer Review Records in Litigation	Our AMA believes that for peer review to be effective, peer review data must be kept confidential. (Sub. Res. 68, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11)	Rescind; superseded by more recent and encompassing policy H-375.962 Legal Protections for Peer Review, particularly: **Privilege.** The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

			Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.
H-375.993	Confidentiality in Medical Staff Peer Review	Our AMA encourages medical staff peer review committees to consider excluding non-physicians when evaluating the professional practices of fully licensed physicians. (Sub. Res. 147, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Rep. 13, I-11)	Rescind; superseded by more recent and encompassing policy H-375.962 Legal Protections for Peer Review, particularly: **Composition of the Peer Review Committee** Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.
H-375.997	Voluntary Medical Peer Review	Our AMA advocates the following principles for voluntary medical peer review: (1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.	Retain; remains relevant.

		(2) Medical peer review should be a local process. (3) Physicians should be ultimately responsible for all peer review of medical care. (4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review. (5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care. (6) Any system of medical peer review should have established procedures. (7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation. (8) Peer review should be an educational process for physicians to assure quality medical services. (9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review. (CMS Rep. A, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation I-98; Reaffirmed: BOT Rep. 8, I-01; Reaffirmation A-05; Reaffirmed: BOT Rep. 5, I-10; Reaffirmed: BOT Rep. 13, I-11)	
H-405.978	Physicians with Communicable Diseases	Our AMA supports the development of general and specific recommendations relating to provision of patient care by physicians infected with communicable diseases of all types. (Res. 222, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain; remains relevant. This policy aligns with recently adopted policy on immunizations by physicians: 8.7 Routine Universal Immunization of Physicians, modified 2020, reads in part "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... including refraining from direct patient contact when appropriate." H-440.831 Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization has similar language regarding practice adjustments.
H-420.954	Truth and Transparency in Pregnancy Counseling Centers	1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further 2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws. (Res. 7, I-11)	Retain; remains relevant.
H-440.946	Health Care Workers and HBV - Nonresponders to HBV Vaccine	It is the policy of the AMA that (1) health care workers who practice invasive procedures and who have been immunized with HBV vaccine be tested for evidence of immunity as determined by a protective anti-HBs level (as currently defined by the United States Public Health Service) one to six months after the completion of an immunization series; (2) such health care workers who fail to respond with an adequate anti-HBs level be counseled about their immune status, its possible impact on their careers, and offered a complete revaccination series; (3) health care workers given a revaccination series be tested again for an adequate anti-HBs level one to six months following the completion of the immunization series. Those who again fail to respond with a protective level should be counseled about the need to continue to follow universal precautions and the risk to their health if they continue to perform invasive procedures; and (4) health care workers be encouraged to maintain HBV immunity by obtaining	Rescind; purpose and intent covered in H-405.978 Physicians with Communicable Diseases.

		appropriate booster immunization when indicated. BOT Rep. X, I-91Reaffirmed: Sunset Report, I-01Reaffirmed: CEJA Rep. 8, A-11	
H-440.949	Immunity to Hepatitis B Virus	It is the policy of the AMA that a health care worker who is at risk for HBV infection, has no immunity resulting from a natural infection, and who has not initiated immunization with HBV vaccine, either be immunized or should abstain from performing invasive procedures. (BOT Rep. CCC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; purpose and intent covered in H-405.978 Physicians with Communicable Diseases.
H-460.906	Enhancing Patient Awareness of Research Participation	Our AMA: 1) will work with relevant health professional associations, patient groups, and the National Institutes of Health to encourage physicians to promote increased awareness among their patients, those who are healthy as well as those with specific diseases or conditions, of the societal and public health benefits of, and opportunities for, research participation; and 2) encourages physicians to participate in practice-based research initiatives and to enroll in practice-based research networks. (Res. 521, A-11)	Retain; remains relevant.
H-460.924	Race and Ethnicity as Variables in Medical Research	Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients. (CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; superseded by recent policy adopted at N-20. See H-65.953 Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, D-350.981 Racial Essentialism in Medicine

H-460.954	Researchers Lending Their Names as Co-authors of Laboratory Findings in Which They Did Not Participate	Our AMA condemns the practice of those persons who permit their names to be used as co-authors of papers publishing laboratory findings in which they did not participate, noting that persons who engage in such practice bear equal responsibility with those who are guilty of falsifying laboratory findings. Our AMA urges editors of scientific journals to reject for publication any paper reporting laboratory findings and research in which any person named as a co-author was not an active participant. (Res. 101, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-460.972	Fraud and Misrepresentation in Science	The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11)	Retain; remains relevant.
H-5.988	Accurate Reporting on AMA Abortion Policy	Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA	Retain; remains relevant.

		policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy. (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	
H-520.987	Condemning the Use of Children as Instruments of War	Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war. (Res. 411, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Retain; remains relevant.
H-525.987	Surgical Modification of Female Genitalia	Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia. (Res. 13, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11)	Rescind; superseded by more recent policy as outlined below: In re: infants and children with differences of sex development, see 2.2.1 Pediatric Decision Making, specifically (c) "Develop an individualized plan of care...in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become." In re: female genital mutilation, see H-525.980 Expansion of AMA Policy on Female Genital Mutilation, which uses the FGM terminology (rather than broad language of "surgical modification" used in the policy at left). Last updated in 2017 it reads: Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the

			procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States.
H-65.978	Nondiscrimination in Responding to Terrorism	Our AMA: (1) affirms its commitment to work with appropriate agencies and associations in responding to terrorist attacks; and (2) opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism. (Res. 1, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; remains relevant.
H-80.995	~~Evaluation of the Use of~~ DNA ~~Identification~~ Testing in Criminal Proceedings	~~(1) A national standard for uniform quality control guidelines should be developed which would govern: (a) appropriate control procedures to minimize the adverse effects of contamination and degradation; (b) an objective standard for identifying separate DNA bands and declaring a match between two or more DNA samples; and (c) the creation and use of population databases which accurately reflect the ethnic composition of~~	Rescind (1), (2) and (3); these have been accomplished by the Organization of Scientific Area Committees for Forensic Science who develop national forensic science

		~~populations amongst which matches might be sought.~~ ~~(2) The independent validation of each probe used for DNA identification testing should be conducted.~~ ~~(3) Further research is needed to determine the effects of contamination and degradation on forensic samples.~~ ~~(4)~~ DNA testing of individuals for information in criminal cases should be conducted only where a warrant has been issued on the basis of a high degree of individualized suspicion. Maintaining the files of any individual who is no longer a suspect in a particular crime raises serious concerns regarding potential violations of privacy. Therefore it may not be appropriate to retain such files. (BOT Rep. FF, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	standards and have published (2020) quality control guidelines that address degradation and DNA probes. The FBI has also published (2020) Quality Assurance Standards for Forensic DNA Testing Laboratories. Retain (4); remains relevant. Numbering removed and title amended as editorial edits.
H-90.987	Equal Access for ~~Physically Challenged~~ Physicians with Physical Disabilities	Our AMA supports equal access to all hospital facilities for ~~physically challenged~~ physicians with physical disabilities as part of the Americans with Disabilities Act. (Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; remains relevant, with editorial changes in title and body to reflect person-first language.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-JUN-21

Subject: Short-term Medical Service Trips

Presented by: Monique A. Spillman, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings abroad for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills. At the same time, short-term medical service trips pose challenges for both volunteers and in prioritizing activities to meet jointly defined goals; navigating day-to-day collaboration across differences of culture, language, and history; and fairly allocating host and team resources in the local setting.

This report by the Council on Ethical and Judicial Affairs (CEJA) explores the phenomenon of short-term medical service trips and offers guidance for physicians and physicians in training to help them address the ethical challenges they face in providing clinical care in resource-limited settings abroad.

THE APPEAL OF SERVING ABROAD

Just how many clinicians volunteer to provide medical care in resource-limited settings abroad is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the nearly 3 billion dollars' worth of volunteer hours spent in international efforts in 2007 were medically related [11]. For trainees, in January 2015 the Consortium of Universities for Global Health identified more than 180 websites relating to global health opportunities [2]. The Association of American Medical Colleges found that among students who graduated in 2017–2018 between 25% and 31% reported having had some "global health experience" during medical school [3].

A variety of reasons motivate physicians and trainees to volunteer for service trips. For many, compelling motivations include the opportunities such trips offer to help address health inequities, to improve their diagnostic and technical skills as clinicians, or to explore global health as a topic of study [11]. Service trips can also serve less lofty goals of building one's resume and improving one's professional prospects, gaining the esteem of peers and family, or simply enjoying international travel [1].

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

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A NOTE ON TERMINOLOGY

The literature is replete with different terms for the activity of traveling abroad to provide medical care on a volunteer basis, including "short-term medical volunteerism" [4], "short-term medical missions" [5], "short-term medical service trips" [6,7], "short-term experience in global health" [8,9], "global health field experience" [10], "global health experience," and "international health experience"[1]. Each has merit as a term of art.

The Council on Ethical and Judicial Affairs prefers "short-term medical service trips." In the council's view, this term is clear, concrete, concise, and does not lend itself to multiple interpretations and possible misunderstanding. Importantly, it succinctly captures the features of these activities that are most salient from the perspective of professional ethics in medicine: their limited duration and their orientation toward service.

MEDICAL SERVICE IN RESOURCE-LIMITED SETTINGS

Traditionally, short-term medical service trips focused on providing clinical care as a charitable activity, not infrequently under the auspices of faith-based institutions, whose primary goal was to address unmet medical needs [9]. Increasingly, such trips focus on the broader goal of improving the health and well-being of host communities [8]. Many now also offer training opportunities for medical students and residents [8,9,10]. Ideally, short-term medical service trips are part of larger, long-term efforts to build capacity in health care systems being visited, and ultimately to reduce global health disparities [8,9].

By definition, short-term medical service trips take place in contexts of scarce resources. The communities they serve are inherently vulnerable, "victims of social, economic, or environmental factors" who have limited access to health care [6]. As one observer noted, those who participate in short-term medical service trips and those who host them "can be characterized, respectively, as 'people who travel easily and people who do not'" [9]. The latter also often lack access not only to health care, but to food, and economic and political power and "may feel unable to say no to charity in any form offered" [9].

The medical needs of host communities differ from those of volunteers' home countries—volunteers may encounter patients with medical conditions volunteers have not seen before, or who present at more advanced stages of disease, or are complicated by "conditions, such as severe malnutrition, for which medical volunteers may have limited experience" [6]. At the same time, available treatment options may include medications or tools with which volunteers are not familiar.

ETHICAL RESPONSIBILITIES IN SHORT-TERM MEDICAL SERVICE TRIPS

These realities of scarcity and vulnerability define fundamental ethical responsibilities not only for those who volunteer, but equally for the individuals and organizations that sponsor short-term medical service trips. Emerging guidelines identify duties not only to maximize and enhance good clinical outcomes, but also to promote justice and sustainability, to minimize burdens on host communities, and to respect persons and local cultures [8,1,9,10].

Promoting Justice & Sustainability

If short-term medical service trips are to achieve their primary goal of improving the health of local host communities, they must commit not simply to addressing immediate, concrete needs, but to

helping the community build its own capacity to provide health care. To that end, the near and longer-term goals of trips should be set in collaboration with the host community, not determined in advance solely by the interests or intent of trip sponsors and participants [8,6]. Trips should seek to balance community priorities with the training interests and abilities of participants [9], but in the first instance benefits should be those desired by the host community [8]. Likewise, interventions must be acceptable to the community [8].

Volunteers and sponsors involved with short-term medical service trips have a responsibility to ask how they can best use a trip's limited time and material resources to promote the long-term goal of developing local capacity. Will the trip train local health care providers? Build local infrastructure? Empower the community [6]? Ideally, a short-term medical service trip will be part of a collaboratively planned longer-term and evolving engagement with the host community [6,9].

Minimizing Potential for Harms & Burdens in Host Communities

Just as focusing on the overarching goal of promoting justice and sustainability is foundational to ethically sound short-term medical service trips, so too is identifying and minimizing the burdens such trips could place on the intended beneficiaries.

Beyond lodging, food, and other direct costs of short-term medical service trips, which are usually reimbursed to host communities [8], such trips can place indirect, less material burdens on local communities. Physicians, trainees, and others who organize or participate in short-term medical service trips should be alert to possible unintended consequences that can undermine the value of a trip to both hosts and participants. Trips should not detract from or place significant burdens on local clinicians and resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt relationships between trainees and their home institutions [8,10]. For example, donations of medical supplies can address immediate need, but at the same time create burdens for the local health care system and jeopardize development by the local community of effective solutions to long-term supply problems [6].

Negotiating beforehand how visiting health care professionals will be expected to interact with the host community and the boundaries of the team's mission, skill, and training can surface possible impacts and allow them to be addressed before the team is in the field. Likewise, selecting team members whose skills and experience map to the needs and expectations of the host community can help minimize disruptive effects on local practice [10]. Advance preparation should include developing a plan to monitor and address ongoing costs and benefits to patients and host communities and institutions, including local trainees (when the trip includes providing training for the host community), once the team is in the field [10].

Respecting Persons & Cultures

Physicians and trainees who participate in short-term medical service trips face a host of challenges. Some of them are practical—resource limitations, unfamiliar medical needs, living conditions outside their experience, among many others. Some challenges are more philosophical, especially the challenge of navigating language(s) and norms they may never have encountered before, or not encountered with the same immediacy [8,1]. Striking a balance between Western medicine's understanding of the professional commitment to respect for persons and the expectations of host communities rooted in other histories, traditions, and social structures calls for a level of discernment, sensitivity, and humility that may more often be seen as the skill set of an ethnographer than a clinician.

Individuals who travel abroad to provide medical care in resource-limited settings should be aware that the interactions they will have in the field will inevitably be cross-cultural. They should seek to become broadly knowledgeable about the communities in which they will work, such as the primary language(s) in which encounters will occur; predominant local "explanatory models" of health and illness; local expectations for how health care professionals behave toward patients and toward one another; and salient economic, political, and social dynamics. Volunteers should take advantage of resources that can help them begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community [6,9,10].

Individuals do not bear this responsibility alone, of course. Organizations and institutions that sponsor short-term medical service trips have a responsibility to make appropriate orientation and training available to volunteers before they depart [10], in addition to working with host communities to put in place appropriate services, such as interpreters or local mentors, to support volunteers in the field.

The ethical obligation to respect the individual patients they serve and their host communities' cultural and social traditions does *not* obligate physicians and trainees "to violate fundamental personal values, standards of medical care or ethical practice, or the law" [8]. Volunteers will be challenged, rather, to negotiate compromises that preserve in some reasonable measure the values of both parties whenever possible [11]. Volunteers should be allowed to decline to participate in activities that violate deeply held personal beliefs, but they should reflect long and carefully before reaching such a decision [12].

GETTING INTO THE FIELD

To fulfill these fundamental ethical responsibilities, moreover, requires meeting other obligations with respect to organizing and carrying out short-term medical service trips. Specifically, sponsoring organizations and institutions have an obligation to ensure thoughtful, diligent preparation to promote a trip's overall goals, including appropriately preparing volunteers for the field experience. Physicians and trainees, for their part, have an obligation to choose thoughtfully those programs with which they affiliate themselves [8,1,9,10].

Prepare Diligently

Guidelines from the American College of Physicians recognize that "predeparture preparation is itself an ethical obligation" [8,cf. 1]. Defining the goal(s) of a short-term medical service trip in collaboration with the host community helps to clarify what material resources will be needed in the field, and thus anticipate and minimize logistic burdens the trip may pose. Collaborative planning can similarly identify what clinical skills volunteers should be expected to bring to the effort, for example, and what activities they should be assigned, or whether local mentors are needed or desirable and how such relationships will be coordinated [10].

Importantly, thoughtful preparation includes determining what nonclinical skills and experience volunteers should have to contribute to the overall success of the service opportunity. For example, a primary goal of supporting capacity building in the local community calls for participants who have "training and/or familiarity with principles of international development, social determinants of health, and public health systems" [9].

Adequately preparing physicians and trainees for short-term medical service trips encompasses planning with respect to issues of personal safety, vaccinations, unique personal health needs,

travel, malpractice insurance, and local credentialing requirements [6]. Equally important, to contribute effectively and minimize "culture shock" and distress, volunteers need a basic understanding of the context in which they will be working [1,6]. Without expecting them to become experts in local culture, volunteers should have access to resources that will orient them to the language(s), traditions, norms, and expectations of the host community, not simply to the resource and clinical challenges they are likely to face. Volunteers should have sufficient knowledge to conduct themselves appropriately in the field setting, whether that is in how they dress, how they address or interact with different members of the community, or how they carry out their clinical responsibilities [6]. And they need to know whom they can turn to for guidance in the moment.

Preparation should also include explicit attention to the possibility that volunteers will encounter ethical dilemmas. Working in unfamiliar cultural settings and health care systems poses the real possibility for physicians and trainees that they will encounter situations in which they "are unable to act in ways that are consistent with ethics and their professional values" or "feel complicit in a moral wrong" [8]. Having strategies in place to address dilemmas when they arise and to debrief after the fact can help mitigate the impact of such experiences. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect withdrawing will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Choose Thoughtfully

Individual physicians and trainees who volunteer for short-term medical service trips are not in a position to directly influence how such programs are organized or carried out. They can, however, by preference choose to participate in activities carried out by organizations that fulfill the ethical responsibilities discussed above [8,9,10]. Volunteers can select organizations and programs that demonstrate commitment to long-term, community-led efforts to build and sustain local health care resources over programs that provide episodic, stop-gap medical interventions, which can promote dependence on the cycle of foreign charitable assistance rather than development of local infrastructure [9].

Measure & Share Meaningful Outcomes

Organizations that sponsor short-term medical service trips have a responsibility to monitor and evaluate the effectiveness of their programs, [8,6,9]. The measures used to evaluate program outcomes should be appropriate to the program's goals as defined proactively in collaboration with the host community [8]; for example, some have suggested quality-adjusted life years (QALYs) [13]. Prospective participants should affiliate themselves with programs that demonstrate effectiveness in providing outcomes meaningful to the population they serve, rather than simple measures of process such as number of procedures performed [6]. Developing meaningful outcome measures will require thoughtful reflection on the knowledge and skills needed to address the specific situation of the community or communities being served and on what preparations are essential to maximize health benefits and avoid undue harm.

RECOMMENDATION

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and vulnerable communities. The realities of scarcity and vulnerability define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.

(b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members bring appropriate skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required

to provide acceptable safe, high quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor's country.

(f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-JUN-21

Subject:	Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"
Presented by:	Monique A. Spillman, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

In conjunction with the adoption of the modernized *Code of Medical Ethics* by the American Medical Association House of Delegates in June 2016, several stakeholders raised concerns that the Council on Ethical and Judicial Affairs' (CEJA) guidance does not clearly distinguish being impaired from having a disability; does not acknowledge that not all illness or disability leads to impairment; and does not clearly address the fact that appropriate rehabilitation or accommodation can enable physicians who are impaired or who have a disability to practice safely.

The following report updates AMA ethics guidance to address these issues.

ILLNESS, DISABILITY & IMPAIRMENT

Opinion 9.3.2 defines impairment as "[p]hysical or mental health conditions that interfere with a physician's ability to engage safely in professional activities..." The fact that a physician has a physical or mental health condition does not necessarily entail that the individual is also impaired. As the Federation of State Medical Boards (FSMB) has noted, "impairment is a functional classification" and that "the diagnosis of an illness does not equate with impairment" [1].This distinction is fundamental to the goals of destigmatizing the conditions that can cause impairment and supporting physicians who become ill or have a disability but are nonetheless capable of safe and effective practice.

Disability leading to impairment has a broad range of meaning as it relates to the ability to practice medicine safely. A variety of physical and mental health conditions (including substance use or conditions related to aging), may result in cognitive or physical changes that can interfere with ability to practice safely. Among physicians, substance use disorder can also be a significant cause of impairment, with some studies showing rates as high as 21% [2]. And while physicians suffer many acute and chronic illness at similar rates to the general public, some illnesses, such as depression, occur with greater prevalence--medical residents, for example, experience depression at a rate of 15-30% compared to 7-8% in the general public [2]. Subtle changes in cognition or motor skills such as those associated with aging are difficult to identify and challenging to interpret with respect to their effect on ability to practice competently and safely. By contrast, sensory or physical disability (blindness, deafness, paraplegia) are often readily identifiable but do not necessarily impair safe practice in selected fields of medicine [1].

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

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Screening and testing can be important for identifying physicians whose ability to practice at accepted professional standards is compromised by illness or disability. Some experts recommend a multi-pronged approach: mandatory testing before employment, random drug testing, evaluations after a sentinel event like a patient death or medical error, and establishment of uniform, national standards to encourage consistency across jurisdictions [3].

However, testing is not without its own challenges. For example, a seemingly straightforward drug test can produce false positive results in response to a legitimate or prescribed substance, and if handled improperly could "destroy a career" [3]. Further, not all testing produces a definitive result. Tests of cognitive or physical capacity may provide some data, but leave important questions unanswered, such as "When does 'decline' become 'impairment'? And when does 'impairment' compromise safety?" [4]. Because impairment is a function of the nature of a physician's practice, test results must be interpreted in context [5]. Screening and/or testing must be fair and thoughtfully implemented to avoid discrimination. Testing should also balance the need to detect impairment with physicians' rights to privacy, autonomy, and due process [3].

RESPONDING TO IMPAIRMENT

Physicians' fiduciary obligation to patients encompasses responsibilities to maintain their own physical and mental health [Opinion 9.3.1], to cultivate self-awareness as a dimension of professional competence [Opinion 8.13], and a responsibility to respond when they believe a colleague is impaired to the extent patients are at risk, in keeping with the profession's overarching duty of self-regulation. These obligations are grounded in the principle that physicians "uphold standards of professionalism" in part by responding to other physicians who are "deficient in character or competence" [Principle II].

Seeking & Offering Assistance

Physicians' responsibility for self-awareness requires that they be sensitive to factors that affect their ability to provide appropriate care, one of which is their own health status. When they become aware that a physical or mental health condition may be interfering with their ability to provide sound patient care, they have a responsibility to address the problem, by consulting their personal physician or seeking other assistance. As CEJA has noted elsewhere,

> Physicians' ability to be sufficiently self-aware to practice safely can be compromised by illness, of course. In some circumstances, self-awareness may be impaired to the point that individuals are not aware of, or deny, their own health status and the adverse effects it can or is having on their practice. In such circumstances, individuals must rely on others—their personal physician, colleagues, family, social acquaintances, or even patients—to help them recognize and address the situation [CEJA Report 1-I-19].

Physicians are professionally responsible to one another and thus have an obligation to respond when a colleague appears to be unable to practice safely. They should intervene with respect and compassion to ensure, first, that the individual no longer endangers patients, and second, that the individual receives appropriate evaluation and care to treat any impairing condition.

Intervention

Ultimately, physicians have an ethical duty to act when colleagues continue to practice unsafely despite efforts to dissuade them, including reporting where appropriate and needed. This responsibility derives from the obligation of self-regulation, a central element of the medical

profession's contract with society to establish and uphold standards of competence and conduct for safe, ethical and effective patient care" [6] In some situations, physicians may have a legal duty to report colleagues whom they believe may be impaired [7].

A host of factors can complicate the duty to report, including not only uncertainty about whether impairment is actually present, but also denial, stigmatization, concerns about practice coverage, and fear of retaliation (especially when reporting a superior) [7]. Health care institutions and state medical boards should offer education and training to help physicians be more effective and comfortable with detecting impairment in the workplace. Fostering an environment where physicians know what to look for and feel comfortable reporting helps protect the well-being of all parties involved. Early detection mitigates harm by catching an impairment before it worsens and creates a less safe practice environment over time [4].

ACCOMMODATING DISABILITY

The 1990 Americans with Disabilities Act (ADA) ushered in a new era of legal protections and rights for people with disabilities, and its impact in creating opportunity and support is felt in health care as elsewhere. An increasing number of physicians with disabilities who are practicing medicine today represent the "ADA generation," individuals who, prior to the legal protections afforded by the ADA, would have been deterred from pursuing a career in medicine [8].

While accommodations that provide physicians with disabilities the opportunity to practice medicine help to ensure a more safe and equitable practice environment for physicians with disabilities, such accommodations also offer benefits more broadly to the patients they serve and by extension can strengthen the patient-physician relationship. Experts recognize that concordance between patients and physicians with disability is key in enhancing quality of care, noting that "increasing the number of physicians who actively identify as having a disability and who require accommodations to practice could improve health care experiences and outcomes for patients with disabilities", as they are better able to "provide patient-centered care" with greater empathy [9, 10]. Removing barriers to practice, when and where they are unnecessary, is ethically required and promotes a more just and diverse workforce [11]. Diversity is essential to combating bias and building empathy; as Ouellette succinctly notes: "one way to counter bias against outsiders [disabled patients] is to make them insiders [physicians]" [10].

Removing barriers should extend to those who seek to enter the profession as well. Technical standards—criteria for medical school admission that require applicants to "demonstrate certain physical, cognitive, behavioral, and sensory abilities without assistance" (emphasis added) [12], create a fundamental barrier for prospective medical students. Experts argue that medical schools should adjust their technical standards from an approach that focuses on students' limitations to a functional approach that focuses on "students' abilities with or without the use of accommodations or assistive technologies" [12] Making such an adjustment is a fundamental step to creating a more inclusive medical profession to the benefit of all. Though there is much work still to be done, the available data suggest that individuals with disability are increasingly successful in becoming educated and trained in medicine. More physicians with disability now enjoy successful careers in medicine [8,13]. Barriers to practice are often "attitudinal or cultural in nature," not barriers born from a valid foundation of safe medical practice [13].

RETURN TO SAFE PRACTICE

Physicians who have undergone successful treatment for an impairing condition or received an accommodation that enables the physician to practice safely should have the right and the

opportunity to practice medicine again. Data has demonstrated, that with proper treatment and help, physicians can successfully recover and return to practice [7,14].

A 2013 report by the FSMB offered guidance for state boards and physician health programs regarding re-entry to practice by impaired physicians [15]. Those recommendations provide for:

- Case by case review informed by FSMB's Policy on Physician Impairment,
- A re-entry plan modeled on the 2012 FSMB guide on re-entry that addressed matters of timing of re-entry, barriers, and common terminology [16].

CONCLUSION

Physician impairment can be the result of any illness or condition - physical or mental. In the interest of patient safety and to meet the profession's ethical obligation of self-regulation, it is important for physicians to be self-aware and sensitive to pressures of training and practice environments and be prepared to respond when signs of impairment are observed, both in themselves and their colleagues. Impaired physicians should receive the intervention and treatment needed and be given the opportunity to rehabilitate and reenter practice safely. Physicians should also be mindful that not all disability and illness cause impairment.

Society, health care systems, educational and training institutions, and practice environments must continue, where possible, to accommodate the needs of all physicians, including those with identified illness and disability. Medical schools should be encouraged to have technical standards that allow for students with non-impairing disabilities to enter the profession. Society and the profession must also have effective mechanisms in place to recognize and respond to physician impairment, in the interest of patient safety and meeting the needs to colleagues who can and want to be rehabilitated and reenter practice. The goal should be that with appropriate care or accommodations a physician will ultimately be able to return to practice safely and effectively, if possible.

RECOMMENDATION

The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues," be retitled as "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" and amended by substitution as follows; and the remainder of this report be filed:

> Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.
>
> While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.

Modify HOD/CEJA policy

Fiscal Note: Less than $500

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SPEAKERS' REPORT 2 (June 2021)
Report of the Election Task Force
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Policy G-610.031, "Creation of an AMA Election Reform Committee," was adopted at A-19 and called on your Speakers to appoint a task force to recommend improvements to our AMA's election process. The task force presented a preliminary report at the 2019 Interim Meeting, and now presents its formal report. The election task force (ETF) diligently studied our current election process, carefully considered the comments received, and reviewed the survey conducted of the HOD at I-19. After extensive deliberation, 41 recommendations are proposed to improve our AMA election process.

The cost of running a successful campaign is generally the most prominent concern expressed. Expense is associated with several components of a typical AMA campaign. The ETF endeavored to reduce campaign costs with an emphasis on eliminating expenses that the HOD found not to be significant factors in the evaluation of candidates or in determining voting decisions. Along these lines the recommendations include elimination of campaign memorabilia, stickers, buttons, and pins, printed brochures, and direct mailing to members of the House while enhancing electronic communication and sponsoring a candidate website. In addition, an AMA reception is proposed to lessen the reliance on independent campaign receptions.

Candidate interviews were identified as the most important decision-making element in the AMA campaigns, yet concerns about equality were expressed. Accordingly, recommendations are offered to enhance and equalize opportunities for interviews.

Concern was raised that there is too much emphasis placed on campaigning and that the election process interrupts and distracts from more important policy discussion. The ETF proposes solutions to streamline our voting processes utilizing new technologies and a specific Election Session to answer this concern. One of the major sources of distraction has been when a current council or board member with an unexpired term creates an unscheduled newly opened position ("pop-up"). Modifying our announcement and nominations process combined with sequential electronic voting in effect eliminates these distractions. Several recommendations are offered to accomplish this.

Careful consideration was given to appointing council positions to eliminate many election issues. Appointment also allows for consideration of diversity and expertise needs. The ETF recommends appointment for a single council while other currently elected councils should continue to be elected.

The ETF believes our recommendations including reaffirming and enhancing our Guiding Principles for Election will provide candidates greater opportunity independent of delegations and caucuses, improve transparency, maintain an informed electorate, and improve fairness in the process.

The recommendations presented represent the consensus of the ETF, and we are confident that they will lead to improvement. However, this can only ultimately become clear once implemented, thus the final recommendation is for a review to be conducted after an interval of 2 years.

REPORT OF THE SPEAKERS

Speakers' Report 2-JUN-21

Subject: Report of the Election Task Force

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Policy G-610.031, "Creation of an AMA Election Reform Committee," was adopted at A-19 and called on your Speakers to appoint a task force to recommend improvements to our AMA's election process. (See Appendix A for actual policy text.) Eleven people, primarily delegates, were appointed to the election task force (ETF) to serve alongside your Speakers, as we are charged with overall responsibility for AMA elections (G-610.020, Appendix B). The appointees are listed in Appendix A, and the task force's preliminary report was presented at I-19 as called for by the policy. Written comments have been solicited and several hours of debate were heard at an Open Forum held at I-19. Over the past two years the Speakers and the ETF have spent well over a hundred hours reviewing our current election processes, discussing concerns and deliberating possible solutions.

The task force defined the following goals specific to our stakeholders:
For candidates: Remove obstacles that discourage qualified individuals from seeking elected positions and improve equity and transparency in the campaign.
For delegates: Provide ample opportunity to gain knowledge about each candidate (informed electorate) without undue distraction from policy development.
For our AMA and our members: Ensure the best possible governance with election of the most qualified candidates to lead our Association.

Election-related concerns that underlay the call to review and improve election rules fall into four categories:

- *Cost, with the consensus being that campaigns are too expensive, which may dissuade some potential candidates, particularly those from smaller societies.*
- *Fairness, with concerns expressed about equality of opportunity for candidates from different delegations given the influence of sponsoring organizations.*
- *Distractions, with elections and the associated activities detracting from the development of AMA policy, which is the House of Delegates' primary purpose under the AMA constitution; this includes time required during House business sessions for speeches and voting, as well as various campaign activities.*
- *Technology, with hope expressed for a move towards electronic communications and more efficient mechanisms for voting.*

These concerns are reflected in the resolutions submitted at the 2019 Annual Meeting, which are reproduced in Appendix C, in comments provided to the task force, and in survey responses provided by members of the House at I-19, which are presented in Appendix D; and are further discussed throughout this document (*set off by italics*). Many of our findings and recommendations relate to more than one of these concerns.

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Current election rules are found in both AMA bylaws and policy (see Appendix B) but are also dependent on some Speaker rulings and discretion (eg, the cap on expenditures for giveaways). In proposing changes to our election processes, the task force has sought to ensure that the best candidates can be selected in free and fair elections while reducing obstacles, or perceived obstacles, that dissuade qualified members from seeking elective office. At the same time the task force has sought not to detract from the ability to ensure an informed electorate.

While this report proposes several changes to current rules, to be effective upon adjournment of this 2021 Special Meeting, worth repeating is a comment from the report of this task force dated November 2019:

> [A]ddressing our AMA's election rules should be an evolutionary process, with the task force's recommendations only a step along a path that is sensitive to changes in technology, the needs of the profession, the diversity of AMA membership and the makeup of the House of Delegates.

Some of the reforms proposed should thus be considered initial steps, with additional changes somewhat dependent on the success—or failure—of the recommendations herein. Members of the task force have considerable experience either as candidates or as members of others' campaign teams, so the recommendations constitute the group's best current, collective judgement. Some of the recommendations flow from comments heard at the open forum and responses to the survey administered at I-19, which proved persuasive in many cases. In addition, several changes that were made of necessity to accommodate the virtual election process for the Special Meetings in June 2020 and 2021 served as models for proposed reforms. Every recommendation, however, derives from a consensus decision within the task force.

Campaign Expense

The cost of running a successful campaign is generally the most prominent among concerns expressed. Whether costs are a real or a perceived problem is unclear insofar as a review of historical evidence shows that large expenditures do not necessarily lead to election. However, the concern does appear to discourage some otherwise qualified candidates from seeking office. Many societies that sponsor candidates are encountering tightened budgets, and concern has been expressed about the wisdom of expending members' dues money on AMA campaigns. Expense is associated with several components of a typical AMA campaign. Some of these are discussed below along with recommendations. The ETF endeavored to reduce campaign costs with an emphasis on eliminating expenses that the survey of the HOD found not to be significant factors in the evaluation of candidates or in determining voting decisions.

CAMPAIGN MEMORABILIA

One of the most obvious expenses incurred by nearly every candidate is some sort of trinket or geegaw, generally imprinted with the candidate's name and distributed in the "not for official business" (NFOB) bag at the opening session of the Annual Meeting. While the overall expenditure is relatively small—a cap of $3445 for such gifts to delegates and alternates at A19—it represents an easily foregone expense. One would surely hope that election decisions are not based on gifts, which over the last few years have included golf tees, pens, lip balm, cookies, candy, water bottles, calculators and small flashlights. In fact, the survey of the HOD found that only 6% of respondents consider these an important factor in determining their vote (see survey results in Appendix D).

Some concern was expressed about doing away with the giveaways, because some candidates make a contribution to the AMA Foundation in lieu of a giveaway. Doing away with giveaways

does not, however, preclude contributions to the Foundation. Anyone and everyone is not only invited but encouraged to donate to the Foundation. Moreover, over the last several years, few candidates have donated to the Foundation in lieu of providing a gift in the NFOB bag. Maintaining giveaways to facilitate relatively rare "in-lieu-of" donations to the Foundation seems a bit disingenuous, particularly as donors can just as easily proclaim their support of the Foundation in more efficient ways.

Your task force struggled somewhat with gifts that are provided by certain delegations in the NFOB bag seemingly every year whether or not they have a candidate. These would fall under the rule for giveaways from candidates in any year in which that delegation had a candidate and a candidate's name was associated with the item, and while not directly linked to a candidate in other years, could be interpreted as an inducement for future candidates from that delegation. In addition, the task force felt any exceptions to the rule would complicate enforcement and potentially lead to a slippery slope with other delegations deciding to supply giveaways every year to remain competitive. In addition, observations at the last two in-person meetings found a majority of the material in the NFOB bag was left on the tables or otherwise discarded. Given the move towards electronic communication and an overall desire to reduce waste, your ETF is recommending the elimination of all campaign materials distributed in the NFOB bag. Although beyond our purview, we believe the other materials that are included in the NFOB bag should also be discontinued or distributed in other more meaningful ways. Ultimately, we believe the entire NFOB bag should be eliminated.

The ETF discussed whether delegations should be allowed to provide token gifts at a reception. For some delegations the gift or raffle item has become a tradition at their reception. The ETF decided not to recommend prohibiting such giveaways as long as they do not include a candidate's name or likeness. We recommend monitoring this to see if delegations attempt to indirectly link these gifts to campaigns or use them as an inducement for a vote, in which case they could be prohibited in the future.

STICKERS, BUTTONS, and PINS

Another area which may seem trivial but adds to the overall cost of a campaign with little to no perceived impact on the election outcome is stickers, buttons, ribbons and pins. While they don't cost much, every dollar counts. In addition to the expense, these items appear to have negative appeal to a number of delegates. Your ETF heard many negative comments about "forced stickering" particularly in receiving lines at receptions. Individuals said they felt pressured to accept and wear stickers, even for candidates they did not support. Others responded that they wear every candidate's stickers, which diminishes the value of all the stickers and clutters their badge. The necessary increased security surrounding our recent meetings, including measures added to our badges, pose an additional argument against stickers, and placing stickers other than on badges may conflict with our enhanced behavior policies. Buttons and pins share similar negatives and create holes in clothing. Finally, all of these, particularly when multiple are worn, project a less than professional image to our meeting and elections. The ETF recommends that campaign stickers, pins and buttons be disallowed.

Distinctly separate from the above are pins and ribbons worn to designate support of AMPAC and our AMA Foundation. Pins for specialties, delegations, regions and even certain causes that do not include any candidate identifier should be allowed. These should be small, not worn on the badge and distributed only to members of the designated group. To prevent a "slippery slope" or problems with enforcement, general distribution of any pin, button or sticker would be disallowed no matter how worthy the cause.

CAMPAIGN RECEPTIONS

A reception is probably the largest single expenditure for most campaigns, with the cost ranging from several thousand to 20 or even 30 thousand dollars, even with our current election rules, adopted by this House several years ago, which disallow alcohol unless available only on a cash bar basis. Such prices make the cost of a reception an impediment or unbearable by some potential candidates. Even candidates from larger delegations have expressed concern about the expense, and some candidates have used personal funds to finance part or all of the expense.

Experience over the last few years also suggests that the impact of a reception on campaign success is, at best, questionable, as candidates who have been featured at a large reception have not been successful in their campaigns, while some with a small or no reception have been successful. Responses to the survey administered at the 2019 Interim Meeting provide support for this position. Fully one-third of the House indicated that receptions are not a factor in determining their votes, and another quarter indicated that receptions were a minimal factor in voting; together those figures constitute three-fifths of the House. Fewer than one in five members of the House indicated that receptions are an important or very important factor in their voting decisions. Yet, your task force heard comments that some delegations wish to continue their receptions.

While a majority of delegates consider receptions of little importance in their election vote, your task force heard multiple comments supporting the existence of receptions for the opportunities they provide for informal social interaction, meeting new individuals and even policy discussion. It is important to note that receptions in their current form are typically open to all, and in fact, candidates seem to be comfortable attending and campaigning at receptions even when sponsored by a competing campaign. Some felt that receptions allowed delegates to interact with candidates (not just the "featured candidate") in an informal and often more personal way.

Current rules allow each candidate to be "featured" (defined in our election rules as being present in a receiving line, appearing by name or in a picture on a poster or notice in or outside of the party venue, …) at only one reception. Delegations or coalitions may finance only a single large reception regardless of the number of candidates from that society or coalition. As noted above, alcohol may be served at these receptions only on a cash bar basis (G-610.020).

Your ETF agrees that there is value to candidates and delegates interacting in social settings outside the rigors of an interview and other formal campaign activities, but we also recognize that the expense of a reception may be a deterrent or cause financial strain for many potential candidates. We hesitate to tell delegations that they may not host a reception but want to create a similar opportunity for other candidates without the resources to host a reception.

In lieu of the multiple, competing receptions sponsored by individual campaigns, we are recommending that our AMA investigate the feasibility of sponsoring a welcome reception open to all candidates and all meeting attendees. Such a reception could allow any candidate the opportunity to be "featured" at the AMA reception. Featured candidates could be allowed to set up in a space within the reception to visit with anyone who chooses to stop by or could choose to circulate among guests. Such an arrangement would do away with the receiving lines, about which the task force heard negative commentary, and the "forced stickering" that seems to occur whenever one enters the current receptions (see above for further discussion of campaign stickers). It would facilitate informal interaction between candidates and members of the House. Two-thirds of those responding to the survey of the House (Appendix D) indicated that they probably or almost certainly would attend such an event. Nothing in this recommendation would prevent other candidates who elect not to use this reception as their single allowed reception from attending.

Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain.

DINNERS, SUITES AND SUCH

Significant money is spent on informal dinners and entertainment in suites. These are often held at AMA events before active campaigning is allowed. These gatherings are inherently difficult to monitor and to enforce potential rules regarding them. Interestingly, these gatherings actually scored better in the HOD survey than large receptions (see survey results in Appendix D). Some say these are a great way to meet fellow delegates while others point to this as an extravagance that many candidates cannot afford.

The task force recognizes that meeting attendees enjoy these informal social gatherings but has sought to reduce the actual or perceived expense of campaigning. The major concern expressed is indeed the cost. To address this the ETF recommends that any group dinners, if attended by an announced candidate (see Announcement and Nomination below) in a currently contested election, must be "Dutch treat," each participant paying their share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Recognizing that candidates should be allowed to dine with a small group of friends or share the tab at the bar without fear of a campaign violation, we propose that gatherings of 4 or fewer delegates or alternate delegates should be exempt.

Given the complexity of enforcement and the relatively less opportunity for excess, the task force does not make any recommendation for limiting interactions in delegation suites at this time. All are reminded that active campaigning prior to the April date, whether in a suite or elsewhere, is specifically prohibited by other rules.

CAMPAIGN LITERATURE

Brochures, letters, flyers and other campaign literature are often mailed to delegates before the Annual Meeting and distributed in the not for official business (NFOB) bag at the opening session. According to the survey of the House (Appendix D), these materials carry little impact on the delegate's vote, regardless of how delivered, yet require significant expenditure to develop, print and distribute. Just six percent of respondents in the House find mailed literature important or very important. Slightly more than half declared that campaign literature was <u>not a factor</u> in determining their vote, and more than a quarter reported it to be of minimal importance. The task force has even heard that a surplus of such material can have a negative impact on a candidate's chances. Campaign material emailed before the meeting fared only slightly better: almost seven percent found it important or very important and three-quarters reported it to be of no or minimal import. Literature distributed in the NFOB bag performed no better than items distributed before the meeting. In fact, a casual survey of the House after the opening session would find most of the campaign literature still in the bags, on the floor, or in receptacles near the exits.

These materials as currently distributed constitute an unnecessary expense and waste of resources particularly because they go unread by the vast majority of delegates. Furthermore, we recognize that some candidates have resources for developing such materials that are not available to other candidates or potential candidates. However, your task force believes an informed electorate needs

to have available information about candidates' background, experience and qualifications for the position they seek. We encourage elimination of all printed campaign materials while recommending an alternate electronic means of providing this information on a more equal platform. It seems few if any candidates "want" to send these materials, but most feel "required" to send because other candidates do. Because mailed materials carry the greatest expense we propose prohibiting these and would end the current process of the HOD office supplying a list of postal addresses to candidates. The election manual has not been printed since 2015 with no apparent negative effects, and in fact, when the House adopted the policy to move to an exclusively online manual, not a single concern was raised, nor have concerns been raised since.

In lieu of printed material, we propose maintaining the online election manual and providing each candidate the opportunity to post materials on the AMA website, within an expanded elections-related set of pages (see discussion below), and the election manual would link to these pages as it does to conflict of interest statements.

ELECTRONIC COMMUNICATION

The AMA rules of contact and privacy policy have been interpreted to not allow the HOD to provide delegate/alternate delegate email addresses to candidates. The ETF has heard that some campaigns have "harvested" email addresses from the pictorial directory and others have not. At best this creates inequality and could even be seen as contrary to the spirit of AMA policy against sharing email addresses. It is necessary that your Speakers and the HOD Office be able to contact members of the House with confidence that the messages will not be regarded as spam; thus your Speakers strive to limit our communications to essential material. At no time was this more clear than leading up to the Special Meetings in the last year. Options of requiring "opting in" or "opting out" so email addresses can be shared with campaigns, as some have suggested, could threaten essential HOD communication. AMA corporate policies would likely be interpreted as not allowing "opting in" as a default and even candidates have expressed that they believe few would elect to "opt in" if required to make this choice.

For the June 2020 Special Meeting, the Speakers, upon request from the majority of candidates, provided the opportunity for candidates to submit material to the HOD office which was then sent electronically by the HOD in a single communication to all delegates and alternates. While this was optional, every candidate took advantage of this opportunity. Parameters were established regarding content, but there was considerable variability in the materials submitted, ranging from resume style materials and photos to simple prose messages or endorsements. Favorable feedback was received and the Speakers have continued this process for June 2021. The ETF recommends continuation of this process even after return to in-person meetings.

A goal of the ETF was to create an equal opportunity for all candidates to share information regarding their candidacy while also reducing the amount of unwelcomed material that delegates receive. At the same time, the task force did not want to create communication rules that would be difficult to track and enforce. While this recommendation does not prohibit candidates from sending their own additional electronic campaign messages, campaigns are reminded that current campaign rules require that any such communication must include an "unsubscribe option." Many delegates expressed that electronic communications from individual candidates are unwanted and may even negatively impact their view of the candidate. Given the electronic communication we propose to be sent by the HOD office on behalf of all candidates it should be anticipated that additional electronic communications from individual candidates would not be well received. With the enhanced opportunity to communicate, we would anticipate less tolerance of mass

communications by candidates and more reporting of the failure to include an unsubscribe option for all such campaign related emails.

WEBSITES AND SOCIAL MEDIA

As mentioned above, the ETF recommends providing each candidate the opportunity to post materials on the AMA website, within an expanded elections-related set of pages. Although the parameters need to be established, the task force envisions a web page template supported by the AMA that could be filled in by candidates without resorting to web design experts. For example, one page might incorporate a biographical resume style listing, another page might incorporate photos of the candidate's selection, and a third page might allow the candidate to post position statements or other information about themselves or that they consider relevant to their campaign. Some design elements might be left up to the candidate (eg, colors and fonts) even while the overall structure of the page(s) is consistent across candidates.

This proposal is supported by the survey of the House at I-19, in which fewer than one in seven delegates indicated that they "probably" or "almost for sure" look at a candidate's website, whereas over half said they would probably or "almost for sure" look at an AMA candidate site. In addition, the fact that all candidate sites would be listed together and linked to the election manual would facilitate delegates review of the material (they would not have to search for individual websites). Candidates would submit their material and all pages would go live simultaneously once campaigning is officially allowed.

At this time, the ETF does not recommend prohibiting candidates from having personal, professional or even campaign-related websites, but the election manual would not link to these independent candidate pages. Similarly, we do not recommend attempting to prohibit or control social media. These forms of communication are embraced by many and importantly individuals must elect to go to the sites or join to receive messages. Since these are not "pushed" to anyone, it should eliminate the concerns of those that feel overwhelmed with electronic information while still providing a resource for delegates that want more information about the candidates.

Fairness
Concern was expressed about inequality of opportunity and the undue influence of caucuses and sponsoring organizations. The ETF hopes that by reducing many of the campaign expenses with the recommendations above, the obstacle of cost will be lowered for all candidates, including those from smaller delegations or with less deep pockets. With all candidates able to participate in the AMA reception, post on the AMA website candidates' pages, and participate in electronic communication originating from the HOD office, opportunities should be less dependent on a candidate's caucus or sponsoring organization. The survey identified interviews as having the greatest influence on the voting decision and our recommendations below should enhance fairness and transparency for this process.

INTERVIEWS

In the survey of our HOD at I-19, candidate interviews were far and away the most important decision-making element in our AMA's election processes, considered an important or very important factor by more than three quarters of those responding (Appendix D). The task force fully agrees with the importance of interviewing.

At the same time, the number of interviews and the time required for them has been likened to a gauntlet for the candidates, and it is no less onerous for those conducting the interviews. For

example, at A-19, interviews for contested slots would require no less than 13 interviews if every candidate was to be interviewed. Ten-minute interviews thus require over two hours, not including any "travel time" between interviews. Added to the actual interviewing time is the time required to arrange and manage these interviews, which is necessary for both the candidates and the interviewers. Yet, virtually every person who spoke on the issue at the open forum, including successful and unsuccessful candidates, expressed the view that the interview process was a valuable experience. A clear majority expressed that interviews were time well spent to meet and become informed about the candidates.

Some delegations expressed that the stream of candidates interrupts their policy deliberations. Other delegations responded that they use interview committees, made up of delegates with special interest in a particular council's activities, which often meet simultaneously with candidates for different races, thus lessening the time required for interviews. The task force believes this may be an acceptable option for some delegations.

Consideration was given to grouping interviews together. Over the past several years the HOD office has coordinated grouping section interviews together but has received negative reaction from the groups preferring to have their own interviews. At the open forum and in communications since there has been broad support from delegations to be allowed to continue their specific interviews. While your task force believes grouping of interviews to reduce the number of interviews is desirable, we believe such grouping is best done voluntarily by delegations that find they share similar interests.

Others suggested that interviews be held in a format in which candidates assemble at an appointed hour in front of those who are interested and questions are asked by a moderator similar to the debate held when the president-elect race is contested. Concerns were raised regarding the stress that would be associated with such a high stakes interview, particularly for council candidates who would not typically face such a situation during council service. Others commented that these interviews often result in candidates repeating or even learning from the responses of those answering before them. The Specialty and Service Society holds such an interview panel, yet many specialty delegations continue separate interviews. Several large delegations and even small delegations confirmed that they would continue their interviews even if such a group interview process was instituted, seemingly adding another round of interviews during an already packed meeting rather than replacing or eliminating interviews.

Of necessity for the June 2020 Special Meeting and now again for J-21, virtual interviews have been conducted by both the Speakers and individual caucuses and delegations. Given the overall positive feedback received, the task force recommends continuing the option for virtual interviews, including recorded interviews by the Speakers, in advance of the meeting even after we return to in-person meetings. In addition, the Speakers would continue to conduct interviews with all candidates to be posted on the AMA website.

Virtual interviews would be allowed during a defined period prior to the meeting in lieu of in-person interviews. Caucuses could choose either method, but not both for a given race. For example, a caucus may choose to conduct virtual interviews for all council races but choose to conduct live interviews for all officer races. These interviews would be facilitated by the HOD Office similarly to how they have been handled for the June 2020 and 2021 campaigns. Recording of virtual interviews must be disclosed to candidates prior to recording and only with their consent, and the recordings may only be shared with members of the interviewing caucus/group.

It has been reported that some candidates have been unable to schedule interviews with some groups, and some groups interview some but not all candidates for a given office. In addition, some candidates have been unaware of the opportunity to interview with some groups or did not know how to arrange such an interview. Democratic principles should favor interviewing all announced candidates for an office. To create equal opportunity for all candidates, we recommend a rule that requires groups electing to interview candidates for a given office to provide an equal opportunity for all currently announced candidates for that office to be interviewed using the same format and platform. An exception would allow a group to meet with a candidate who is from their own delegation without interviewing other candidates. This rule would apply to both virtual and in person interviews.

Distractions and Technology

Concern raised was that there is too much emphasis placed on campaigning and that the election process interrupts and distracts from more important policy discussion. Others expressed that election of leadership is an essential function of our House and a core responsibility of delegates. Your ETF believes both viewpoints are valid and has sought to design a process that is less disruptive to our policy deliberation, consumes less time, and yet allows for secure voting. This can be accomplished by streamlining our processes and utilizing new technologies.

VOTING PROCESS AND ELECTIONS SESSION

Our current voting process at in-person meetings crafted by bylaws, rules, and tradition developed 20 plus years ago involves casting ballots in a separate room in "voting booths" on Tuesday morning during a 75-minute voting window. Results for each race are announced in the House once they become available, typically 30-40 minutes after the House has come to order, interrupting the discussion of reference committee reports. Oftentimes, runoff voting is required and accomplished using paper ballots which are printed, distributed, collected and counted (by hand) by the election tellers, again disrupting the policy discussion. If new openings are created, new nominations, speeches, voting and possibly further runoffs all interrupt House debate. Twice in the last several years elections have extended to Wednesday morning. Voting delegates must be seated at these somewhat random moments to receive a ballot, resulting in reshuffling of delegates and alternate delegates, further disrupting the deliberations. All of this when combined with appreciation and concession speeches, consumes considerable time and detracts from policy discussion. While initial voting is secure in a private booth, runoff paper ballots are distributed in the House to credentialed delegates only, but there is little actual security in this regard as ballots are "passed down the row."

The original resolutions adopted by the HOD specifically called for consideration of electronic voting. In 2020, in the virtual format, all the voting was done electronically by necessity. Electronic voting was secure and effective in the virtual situation and should be acceptable in person. We are confident that voting can be done with the electronic voting devices—colloquially referred to as "clickers"—that are used in business sessions of the House. The devices are easy to use, and their security and privacy features are at least as great as current methods. Briefly described, delegates (not alternate delegates) can be issued a security card that must be inserted into the device in order to vote in elections. While all devices can be used to vote on policy matters without the card, the security card is required to cast a vote in an election. Each vote should take under a minute, results are almost instantaneous and the devices can be reset for a runoff election within a minute or two. Given the virtual nature of the June 21 HOD meeting, election voting will again be electronic. Accordingly, the ETF recommends that electronic voting should be continued when we return to in-person elections at the 2022 Annual Meeting. We believe this change will simplify voting, allow results of each race including runoffs to be known before ballots are cast for the next position and

facilitate a new method of handling positions that were unscheduled but created by a prior election result, henceforth "newly opened positions" (see Newly Opened Positions below).

To further reduce the interruption of policy discussion, our Speakers have scheduled a specific "Election Session" on the agenda for the June 21 HOD meeting. All election activity (except for those unopposed candidates elected by acclamation at the time of nominations) including voting, runoffs and speeches will occur at a scheduled time on Tuesday morning (see discussion on "the day of elections") separate from policymaking sessions. The House deliberation of reference committee reports will resume at a "time certain" to be specified. Delegates only will be voting at this time, but alternates and guests are welcome to observe. The ETF recommends continuing this scheduling once in-person meetings resume.

Additionally, while the task force understands the tradition of thank you speeches by both the victors and unsuccessful candidates, the task force nevertheless prefers that all such speeches be discontinued. No one doubts the sincerity of the thank you delivered by those speaking, but those words of appreciation could better be delivered privately. Moreover, sparing losing candidates the discomfort, often palpable throughout the House, of appearing at a microphone shortly after hearing negative results should be considered a kindness, not a slight, and allows them a graceful exit. These "points of personal privilege" were not heard in June 2020 and will not occur in June 2021. Candidates were invited to share written comments which were subsequently sent to the House. The Speakers have heard no complaints regarding this decision. Our intention is not to create a rule disallowing these speeches (since no rule allowing them exists), but rather to set the stage for the Speakers to use their discretion based upon the volume of business at hand and the number of candidates. We encourage the Speakers to continue to collect personal points from candidates and share them electronically with the House after the meeting, eliminating the need for the speeches during the meeting itself. If such speeches are allowed in the future, we strongly suggest that they be limited to 60 seconds.

With these proposed changes, the task force believes voting will be secure, the time consumed for elections will be greatly reduced, and there will be no interruptions of policy discussion.

ANNOUNCEMENTS AND NOMINATIONS

The ETF considered various announcement/nomination scenarios with the intent of clarifying this process, increasing vetting of all candidates, ameliorating the negative aspects of "pop-ups" (see Newly Opened Positions below) and maintaining the time limit on active campaigning to the period of April through June.

Currently candidates for all elected positions may announce their candidacy with a virtual card projected at the conclusion of the Annual and/or Interim Meetings and then posted on the AMA candidate website. In addition, current rules allow candidates that do not submit an announcement card at these times to send an announcement to delegates even before the "active campaign" has begun. As a result candidates may in effect announce their candidacy directly to delegates at any time, making it difficult to stay abreast of all current candidates for a particular position.

The ETF believes that this loophole should be closed and that such announcements, just like any other campaign communication, sent to delegates before active campaigning is allowed would be a violation of campaign rules. In addition, we propose additional "official" announcement dates be established at which time additional announcements cards would be added to the AMA website and communication would be sent to the HOD. Under our proposal any candidate could still

independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

We propose that the HOD office review all known candidates following the Annual and Interim Meetings and at other specified announcement times to identify unscheduled seats that may potentially be newly opened by election of any announced candidates and communicate this information to the House along with the names of all the candidates for each position. These "Official Candidate Notifications" would add transparency and alert delegations and members of the possibility of unscheduled positions that may become open if certain announced candidates are elected. Members interested in becoming candidates for open or potential newly opened positions would be required to send a virtual announcement card to the HOD Office and complete a conflict of interest (COI) form.

The AMA Board of Trustees considers applications from council candidates at its April meeting and then announces the candidates shortly thereafter. Active campaigning is allowed after this announcement. Currently there is no official notification and oftentimes delegates are uncertain of the exact date of the BOT meeting and start of active campaigning. Therefore, at this time another "Official Candidate Notification" would be sent to the HOD. This would also signal the start of the active campaigning period. Subsequent "Official Announcement Dates" would be determined by the Speakers.

Candidates who become aware of potential newly opened positions for any office or council could notify the HOD Office at any date of their intent to join the campaign and then would be included at the next official announcement and in all subsequent announcements. Presumably this would occur well before nominations occur at the Opening Session of the House. All previously announced candidates will continue to be included at each official announcement (i.e. those announced in June will again be presented in November, April, etc.) and all who had notified the HOD Office of their intent to be nominated and completed a COI would be included in any campaign activity that had not yet been finalized. This modified announcement process would not prohibit late entry into the campaign but provides advantages to early entries.

As discussed below, our bylaws allow for nomination "from the floor" during the Opening Session of the HOD, so candidates could elect to be nominated who had not notified the HOD office of their intent and who had not been included in any official announcement. While it would still be possible for a new candidate to first announce at the time they are nominated from the floor at the Opening Session of the House, waiting until this moment when given the opportunity to announce their candidacy in advance, would seem to put that candidate at a significant disadvantage, thus encouraging candidates to announce early and be vetted. The earlier the announcement, the more the opportunity to participate in the campaign process, including interviews which the survey identified as the most important factor in the voting decision. This proposal would allow for posting of the COI at the time of announcement (likely well before election day) or at the latest at the Opening Session of the House, more than two days before the election in our current schedule.

The task force carefully considered the bylaws that allow for nominations from the floor during the Opening Session. This bylaw is common among associations that hold open nominations and elections. Typically nominations are declared open and then closed by a motion. No doubt this option complicates the campaign process and potentially creates chaos at the last moment. However, nomination at the last possible minute allows for the rare case where a candidate is determined to be unavailable or unacceptable to fill a position, or a late nominated candidate for some reason is an overwhelming choice. While relatively rare, this has occurred, and candidates waiting until this last moment have been elected. The ETF believes this option should remain and

recommends the more formalized announcement process as a solution to at least the most common aspects of the problem of late announcements and unvetted candidates.

During the ETF exploration of announcements and nominations we found inconsistencies in our rules surrounding the concept of announcements versus nominations. These two terms seem to be used interchangeably without a clear delineation between the two. For example, we could not find a basis for the Board nominating council candidates in conjunction with the April Board meeting. Bylaw 6.8.1 specifies that nominations for the elected councils are made by the Board **or** by a delegate from the floor. It does not specify when the Board actually places the names of their nominees into nomination. In fact, as discussed in the paragraphs above and below all nominations actually occur at the Opening Session of the House. Under the current process, candidates for council positions submit applications to the Board for consideration at their April meeting prior to an established March 15 deadline as discussed in Policy G-610.010, "Nominations," shown below [*emphasis* added]:

> Policy G-610.010, Nominations
> Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of nominations to the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

These "nominations" are then announced at the conclusion of the Board's April meeting at which time active campaigning may begin. Policy G-610.020 which reads in item 3 [*emphasis* added]:

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

It is our understanding that Policy G-610.020 (3) was written more to define the start of active campaigning rather than to specify the timing of the nomination process. Note that this only specifies the Board "announcing the nominees" for council candidates; they are actually nominated by the Board at the Opening of the House. However, council candidates under our current rules may "announce" their candidacy at any point, even after the March deadline, and then be nominated "from the floor" by a delegate without completing an application or being considered by the Board. Review of available history did not identify a single instance when the Board did not "nominate" a council candidate who submitted an application. In reality the Board review of these candidates, who must be AMA members, is largely perfunctory. Procedurally nominations are declared open by the presiding officer, nominations are announced by the presiding officer or Board chair or made from the floor by a delegate. Then a motion is accepted to close nominations (typically the presiding officer will accept nominations be closed "without objection" once no further nominations appear to be pending even without a formal motion and second). To eliminate

the confusion between nomination and submitting applications for review by the Board at their April meeting while maintaining the uniform March 15 deadline, the ETF recommends Policy G-610.010, "Nominations," paragraph 3 be amended.

> Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

In addition, Policy G-610.020 (3) be amended by deleting the word "nominees" and inserting the word "candidates" to clarify that the Board is announcing the candidates and not actually nominating them.

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

The ETF believes these proposed changes to our announcement process will clarify the process while maintaining the current nominations that occur at the Opening Session of the House. These changes provide transparency for delegates to know the candidates for all positions and have an opportunity to vet those candidates. It also allows potential candidates to learn of the opportunities to run for an unscheduled position that may become newly open as a result of another pending election.

NEWLY OPENED POSITIONS

Significant concern was raised regarding how to handle elections to fill previously unscheduled vacancies that are created as a result of prior elections. This most often occurs when a council member with an unexpired term is elected to an officer position but may also occur when a current Board member with a continuing term becomes president-elect. Current bylaws prescribe that the newly opened position is filled in a separate election with nominations to be held after completion of election for previously known open positions. Over the past several years multiple previously unannounced candidates are then nominated, all candidates give a speech before the House and then voting ensues. In the past these have been called "pop-ups."

Three general concerns have been expressed regarding "pop-up:" first, these individuals are being elected without the usual vetting; second, the process of new nominations and speeches before the HOD delays and distracts from policy discussion; and third, the possibility of opening a seat has become a campaign strategy. In addition, our rules require a conflict of interest disclosure to be

submitted before the election and presumably there should be ample opportunity for delegates to review the COI before voting. The ETF considered a number of potential solutions, including requiring candidates seeking another office to resign their current position, leaving the seat of a successful candidate vacant until the next meeting, delaying voting on these positions until the next day, or forcing potential candidates to declare in advance (an analysis of each of these options is included in Appendix E).

These options were discussed at the open forum held at the 2019 Interim Meeting and were also a subject of the survey of the House. Each option received support and opposition, with no consensus reached, but a majority favored some change over the current process. After further exploration, the ETF discovered that simply embracing newly available voting technology that allows sequential voting with nearly instantaneous results and rapid ballot preparation eliminates most of the problems associated with "pop-ups" without necessitating the more radical changes associated with the options presented at I-19.

The problems associated with newly opened positions are the result of the limitations of our current voting process. The change in our election process to electronic voting as detailed above (see Election Process) technically eliminates "pop-ups." Pop-ups occur only when a new position opens "that did not exist at the time of the prior ballot" (Bylaws 3.4.2.2 and 6.8.1.5). With sequential electronic voting all open positions, including those created by a preceding vote for an officer position, will "exist" at the time of the initial ballot. During the election session, proposed above, the vote for the Board of Trustees will be held (including any runoffs) with the results known, before the first ballot and voting for the councils will occur. With this process there has been no "prior ballot" for any of the councils. Similarly, the vote for president-elect will be concluded before the voting for the Board begins. For example, hypothetically a current member of the Council on Medical Service (CMS) with an unexpired term is elected to the Board; the first vote for CMS will occur after the result of the Board election is known. Therefore, the first ballot for CMS will include candidates for all open seats including the newly opened position. With this process there is no "newly opened seat that did not exist at the time of the first ballot," thus no "pop-up," no new nominations, and no speeches before the House. Based upon the change to electronic voting for each position in a sequential fashion, Bylaws 3.4.2.2 and 6.8.1.5 are no longer relevant, and we recommend they be rescinded to eliminate future confusion.

While this technically eliminates "pop-ups,"" this does not completely solve the problem. Nominations are accepted on Saturday afternoon (in our usual meeting schedule) and elections are held on Tuesday. Therefore, candidates who are considering nomination do not know whether a newly opened position will be created before the close of nominations. To solve this problem, the ETF is suggesting a modified announcement and nominations process that entails informing delegates at specific times in advance of the meeting of the current candidates for each position and the seats that could potentially be newly opened as a result of pending elections (see Announcements and Nominations). The proposed process as detailed above includes a series of announcement deadlines with notification sent to delegates with subsequent opportunity for new candidates to announce their intention to run for these potential newly opened positions. This proposed announcement process will encourage candidates to announce in advance for potential newly opened positions and require candidates that hope to be elected to one of these positions to be nominated during the Opening Session of the House. Changes suggested below will allow candidates the opportunity to withdraw their nomination in the event the potential seat does not open. However, once nominations are closed, no further nominations will be accepted. This proposal, while requiring candidates to be nominated for a position that may not ultimately open, will allow vetting of candidates that announce their intention to be nominated.

Currently when an unopposed candidate with an unexpired term is elected by acclamation, nominations for the newly opened council or Board seat are accepted at the time of initial nominations along with nominations for any previously known open seats. In fact, this is the model we have used above in our proposal to handle potential newly opened positions.

If there are no open positions scheduled for election in a given year for a particular council or the Board, but there is the potential for a newly opened position (one or more current candidates for a higher office hold an unexpired term on a council or the Board) candidates will be solicited as detailed above for the potential newly opened position. These announced candidates for the potential newly opened position will proceed with all campaign activities available to them from the time of their announcement forward. If the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election will be held. In this event these candidates will have campaigned even though there ultimately was no vote. The ETF considered that this may be an unnecessary burden on the candidates, but thought that this campaign experience and the resulting exposure of the candidate to the House would actually be beneficial to the candidate.

If the potential newly opened position does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. This will allow candidates from the same delegation to avoid potential conflicts. Conversely, all candidates may also choose to continue with the election to compete for the available positions.

Following the implementation of electronic voting during a specified election session and the proposed new announcement process, in the unlikely event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position(s) would remain unfilled until the next Annual Meeting.

There is no perfect solution to the problem of newly opened positions, but the ETF believes this proposal will encourage candidates to announce their candidacy early, add transparency to our elections, result in more contested elections, allow delegations the opportunity to vet candidates for newly opened positions, and eliminate the distraction from policy discussion that occurs with our prior "pop-up" process.

APPOINTING SELECT COUNCILS

Careful consideration was given to the idea of appointing some or all of the currently elected council positions. Appointment would eliminate most if not all the issues of concern heard regarding elections. In addition, appointment by a nominations committee allows for careful consideration of diversity and expertise needs of a council.

The concept of appointing members to councils has several precedents within our AMA. Current rules provide multiple methods of selecting appointed councils (CLRPD--selected by the BOT and the Speaker, COL--selected by BOT, CEJA--nominated by the President), the public member of the Board is chosen by a search committee and confirmed by the HOD, and the House Compensation Committee is a combined appointment by the President and the Speaker. These committees function well with the members selected by the current appointment process and the task force does not recommend any change in these councils.

In addition, these various methods all enjoy a plethora of candidates for each position which is in contrast to the few candidates, often unopposed, that run for councils. This may reflect a desire by

some to avoid the election process which has been called into question by the resolutions that called for this report. It can be argued that more candidates would come forward if councils were appointed. Appointing one or more councils would lessen the number of interviews and remove most if not all associated campaign expenses.

The task force believes that all officers and most council members should continue to be elected, but recommends that the Council on Constitution & Bylaws (CC&B) should be transitioned over to selection by appointment. This council, perhaps more than any other council, benefits from members with particular backgrounds and skill sets that are not always appreciated in our campaign process. For example, during interviews candidates for CC&B are rarely asked questions regarding bylaws. Over the past several elections CC&B has attracted relatively few candidates as compared to other elected councils and far fewer than appointed councils.

Concern was expressed that service on a council often leads to future leadership positions and appointment may have a deleterious effect on the potential of council members moving forward. A review of current and recent past successful officer candidates found that there was a balance between those that had previously served on elected and appointed councils, and in fact a lower representation of past CC&B members.

The specific process of appointment could be determined subsequently, but the task force favors a process that would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged.

THE ROLE AND INFLUENCE OF CAUCUSES

Concerns about the role played by caucuses in the election process have been heard for many years, perhaps getting louder as caucuses have grown larger. There is little question that delegations and caucuses have significant influence in our elections.

These caucuses are often the source of interviews of candidates and subsequently suggest to varying degrees voting for particular candidates. A small number of delegates (5%) in the HOD survey responded that they felt their vote was "mandated" by their delegation and others, while still a minority (15%), said they felt "strong pressure" to vote for particular candidates. Meanwhile, our current guiding principles for elections, Policy G-610.021 [*emphasis* added] clearly states –

> 1. AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) <u>make independent decisions about which candidates to vote for</u> .

Insofar as AMA's elections are conducted by secret ballot, the task force believes that delegates ought to be able to hew closely to these principles with little fear of repercussions. Further review of the survey results show that almost ⅔ of the respondents (65%) "make their own decision" with or without input from their delegation or caucus. This is not meant to suggest that delegates should ignore their sponsoring organization's endorsements, only that the sponsoring organization's recommendations are but a single element in a delegate's decision-making armamentarium with respect to elections.

Others say they are offended by "vote trading and deals" made within and between caucuses. The ETF notes that our principles go on to state:

> 2. Any electioneering practices that distort the democratic processes of the AMA-HOD elections, such as vote trading for the purpose of supporting candidates, are unacceptable.

As such it seems rules already exist to address these issues. The ETF strongly recommends that these policies be reaffirmed and that efforts should be made to make delegates more aware of these principles. In addition, we recommend Principle 2 should be strengthened by adding the following: "This policy applies between as well as within caucuses and delegations."

Furthermore, we recommend addition of another principle to discourage delegations from using "rank order" lists of candidates and encourage delegations to provide an opportunity for their members to have an open discussion regarding candidates.

Candidates typically seek nomination and endorsement from the groups with which they associate or with whom they have perceived connection. Some argue that this provides a desirable screening of candidates and a way to gain support. Others see this as controlling who is allowed to become a candidate and preventing some qualified individuals from entering a race. The ETF believes delegations and caucuses should have autonomy in deciding whom they support as candidates, but we emphasize that the goal of our elections should be to select the most qualified leaders for our Association. As such we propose another additional guiding principle for election as follows:

> (8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

In addition, the ETF believes other recommendations within this report (recorded interviews, posted website materials, electronic communications originating from the HOD Office, etc.) will provide candidates more opportunity independent of the assistance from well funded delegations and large caucuses. Any candidate will be able to participate in the AMA reception providing them exposure without the need for a separate reception. Several other recommendations should also reduce the expense of campaigns, further reducing the influence of delegations and caucuses.

During the task force discussions, the question was raised about the size of caucuses. That is, should the size of a caucus be capped such that its influence—whether real or perceived—does not become outsized? The task force is not making a recommendation on this matter at this time. It remains a question whether limitations on caucuses are within the House's authority at all. The ETF recommends continued monitoring of the effects of the adopted recommendations and consideration of future changes should they be deemed necessary.

THE DAY OF THE ELECTIONS

The task force heard suggestions for moving the day of the elections to earlier in the Annual Meeting, but does not favor such a change. First, determining who are the best candidates takes time, and the time devoted to interviews is valued by both candidates and the electorate. An earlier date would increase reliance on speeches and written materials rather than "getting to know" the candidates. Truncating the vetting process would be most harmful to lesser known candidates and those from smaller delegations. After examining the other days of the Annual Meeting, the ETF concluded that moving the elections would cause greater disruption to the already full agenda for each of the other days. The potential to adversely affect the elections by moving them forward

seems too great to alter the day of the elections. Therefore, the task force favors implementation of the reforms proposed herein, which we believe will address the concerns underlying proposals to move the day of elections. (See Appendix F for detailed discussion of the ETF consideration of alternative days of election.)

ELECTION COMMITTEE

At the open forum discussion at I-19 the idea of an ongoing election committee was proffered and received broad support. The concept was not to detract from the Speakers' role in overseeing the campaign and election process, but rather to provide them support. Recognizing that improvement in our elections is an iterative process, a committee could monitor the impacts of the recommendations adopted from this report and make further recommendations for the continued evolution of our election process. In addition, it was mentioned that enforcing campaign rules could create real or perceived bias for a Speaker if the complainant or the accused happened to be a friend or from their delegation. The committee working with the Speakers could adjudicate potential campaign violations. The Speakers are receptive to this proposal.

The ETF recommends establishment of an Election Committee of 7 individuals, appointed by the Speaker for 1-year terms to report to the Speaker. We proposed that these individuals be allowed to serve up to 4 consecutive terms but that the maximum tenure be 8 years. These individuals would agree to not be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups to reduce potential bias. The primary role of the committee would be to work with the Speaker to adjudicate any election complaint. The ETF envisions selection of a smaller subcommittee from the Election Committee to adjudicate each specific complaint. Additional roles could include monitoring election reforms, considering future campaign modifications, and responding to requests from the Speaker for input on election issues that arise. Our Bylaws (2.13.7) provide for the appointment of such a committee. This Bylaw specifies that the term may be directed by the House of Delegates. Therefore, the ETF recommends that such a committee be established for the terms noted.

In addition, the task force recommends a more defined complaint and violation adjudication process including the proposed Election Committee. Details can be further determined by the committee in consultation with the Speakers and presented to the House at a future date, but the ETF suggests consideration of a more formal process for reporting, validation of the complaint with investigation as needed, resolution of the concern and presentation to the HOD if a formal penalty (up to and including exclusion from the election) is deemed appropriate.

REVIEW OF IMPLEMENTATION

The above recommendations are all derived from our extensive review and deliberation of our AMA election process. These recommendations represent the consensus of the ETF and we are confident that they will lead to improvement. The House of Delegates will undoubtedly have opinions as to whether these are the right solutions but the ultimate determination will only become clear once the adopted recommendations are implemented. Therefore, our final recommendation is for a review to be conducted after an interval of 2 years led by the Speaker and at the Speaker's discretion, the appointment of another election task force, with a report back to the House.

CONCLUSION AND RECOMMENDATIONS

Our AMA election process is guided by our bylaws, various policies adopted by the HOD, the HOD Reference Manual and tradition with overall responsibility resting with the Speaker. As such, the following recommendations, if adopted, will require thorough review and editing of these documents to reflect the changes.

Following the detailed discussion above, the Election Task Force recommends that the following recommendations be adopted, with the rules to be effective upon adjournment of this meeting, and the remainder of this report be filed. Recommendations are listed in order of the topics covered in the body of the report with all modified current policies reconciled in numerical order in Appendix G for clarity.

Campaign Memorabilia

Recommendation 1: Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag. (New HOD Policy)

Recommendation 2: Policy G-610.020, Rules for AMA Elections, paragraph 10 be amended by addition and deletion to read as follows:

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

Stickers, Buttons, and Pins

Recommendation 3: Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed. (New HOD Policy)

Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 8 be amended by deletion to read as follows:

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

Campaign Receptions

Recommendation 5: Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two year trial with a recommendation for possible continuation of the AMA reception. (New HOD Policy)

Recommendation 6: Policy G-610.020, Rules for AMA Elections, paragraph 8 be reaffirmed (minus phrase "c" recommended for deletion above):

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

Dinners, Suites and Such

Recommendation 7: Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule. (New HOD Policy)

Recommendation 8: Policy G-610.020, Rules for AMA Elections, paragraph 6 be amended by addition and deletion to read as follows:

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

Campaign Literature

Recommendation 9: Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials. (New HOD Policy)

Recommendation 10: Policy G-610.020, Rules for AMA Elections, paragraph 9 be amended by addition and deletion to read as follows:

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

Recommendation 11: The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates. (New HOD Policy)

Recommendation 12: Policy G-610.020, Rules for AMA Elections, paragraph 5 be amended by addition and deletion to read as follows:

(5) A reduction in the volume of telephone calls and electronic communication from candidates~~,~~ ~~and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages; (Modify Current HOD Policy)

Recommendation 13: An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates. (New HOD Policy)

Recommendation 14: Policy G-610.020, Rules for AMA Elections, paragraph 4 be amended by addition to read as follows:

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates; (Modify Current HOD Policy)

Interviews

Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 14 be reaffirmed:

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

Recommendation 16: Delegations and caucuses may conduct interviews by virtual means in advance of the Annual Meeting of the House of Delegates during a period of time to be determined by the Speaker in lieu of in-person interviews at the meeting. Delegations and caucuses may choose either method, but not both for a given race. Groups electing to interview candidates for a given position must provide an equal opportunity for all candidates for that position who have announced their intention to be nominated at the time interviews are scheduled, to be interviewed using the same format and platform. An exception being that a group may elect to meet with a candidate who is from their own delegation without interviewing other candidates. Recording of virtual interviews must be disclosed to candidates prior to recording and may only be recorded with candidate consent. Interview recordings may only be shared with members of the interviewing caucus/group. (New HOD Policy)

Recommendation 17: The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website. (New HOD Policy)

Voting Process and Election Session

Recommendation 18: Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker. (New HOD Policy)

Recommendation 19: Policy G-610.030, Election Process be amended by addition and deletion to read as follows:

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

Recommendation 20: The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments. (New HOD Policy)

Announcements and Nomination

Recommendation 21: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition to read as follows:

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

Recommendation 22: Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker. (New HOD Policy)

Recommendation 23: Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times. (New HOD Policy)

Recommendation 24: Policy G-610.020, Rules for AMA Elections, paragraph 15 be reaffirmed:

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents. (Reaffirm HOD Policy)

Recommendation 25: Policy G-610.010, Nominations be amended by addition and deletion to read as follows:

> Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; (Modify Current HOD Policy)

Recommendation 26: Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:

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

Newly Opened Positions

Recommendation 27: The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions. (New HOD Policy)

Recommendation 28: If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. (New HOD Policy)

Recommendation 29: If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. (New HOD Policy)

Recommendation 30: In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting. (New HOD Policy)

Recommendation 31: Bylaws 3.4.2.2 and 6.8.1.5 be rescinded.

> **3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot**. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.
>
> **6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot.** The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted. (Modify Bylaws)

Appointing Select Councils

Recommendation 32: Members of the Council on Constitution & Bylaws (CC&B) will be appointed. The appointment process would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged. Appropriate bylaws to accomplish this change will be crafted by CC&B. (Modify Bylaws)

The Role and Influence of Caucuses

Recommendation 33: Policy G-610.021, Guiding Principles for House Elections, principle 2 be amended by addition to read as follows:

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations. (Modify Current HOD Policy)

Recommendation 34: Policy G-610.021, Guiding Principles for House Elections, principles 1, 3, 4, 5 and 6 be reaffirmed:

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position. (Reaffirm HOD Policy)

Recommendation 35: Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 7 to read as follows:

(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates. (Modify Current HOD Policy)

Recommendation 36: Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 8 to read as follows:

(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support. (Modify Current HOD Policy)

The Day of the Elections

Recommendation 37: Policy G-610.030, Election Process, paragraph 1 be reaffirmed:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; ... (Reaffirm HOD Policy)

Election Committee

Recommendation 38: In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. (New HOD Policy)

Recommendation 39: The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties This process will be presented to the House for approval. (New HOD Policy)

Recommendation 40: Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by addition to read as follows:

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

Review of Implementation

Recommendation 41: After an interval of 2 years a review of our election process, including the adopted recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House. (New HOD Policy)

Fiscal Note: Up to $250,000 if AMA elects to sponsor a reception, depending on the number of people and food and beverage.

APPENDIX A – Task Force Charge and Membership

Policy G-610.031, Creation of an AMA Election Reform Committee
Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

- Jenni Barlotti-Telesz, MD, American Society of Anesthesiologists
- Richard Evans, MD, Maine
- James Hay, MD, California
- Dan Heinemann, MD, American Academy of Family Physicians
- David Henkes, MD, Texas
- Jessica Krant, MD, American Society for Dermatologic Surgery
- Josh Lesko, MD, Resident Physician, Virginia
- John Poole, MD, New Jersey
- Karthik Sarma, past medical student trustee
- Stephen Tharp, MD, Indiana
- Jordan Warchol, MD, MPH, Nebraska
- Bruce Scott, MD, Speaker, Kentucky
- Lisa Bohman Egbert, MD, Vice Speaker, Ohio

APPENDIX B – Current AMA Election Rules and Policies

CONSTITUTION

Article IV House of Delegates

The House of Delegates is the legislative and policy-making body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws.

BYLAWS

3—Officers

3.1 Designations. The officers of the AMA shall be those specified in Article V of the Constitution.

3.2.1 General. An officer, except the public trustee, must have been an active member of the AMA for at least 2 years immediately prior to election.

3.2.1.3 Restriction on Chair. The Chair of the Board of Trustees is not eligible for election as President-Elect until the Annual Meeting following completion of the term as Chair of the Board of Trustees.

3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made from the floor by a member of the House of Delegates. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made from the floor by a member of the House of Delegates and may be announced by the Board of Trustees.

3.4 Elections.

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

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

3.4.2.1 At-Large Trustees.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of

Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

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

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

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

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

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

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

3.5 Terms and Tenure.

3.5.1 President-Elect. The President-Elect shall be elected annually and shall serve as President-Elect until the next inauguration and shall become President upon installation at the inaugural ceremony, serving thereafter as President until the installation of a successor. The inauguration of the President may be held at any time during the meeting.

3.5.2 Speaker and Vice Speaker. The Speaker and Vice Speaker of the House of Delegates shall be elected annually, each to serve for one year or until their successors are elected and installed.

> **3.5.2.1 Limit on Total Tenure.** An individual elected as Speaker may serve a maximum tenure of 4 years as Speaker. An individual elected as Vice Speaker may serve for a maximum tenure of 4 years as Vice Speaker.

3.5.3 Secretary. A Secretary shall be selected by the Board of Trustees from one of its members and shall serve for a term of one year.

3.5.4 At-Large Trustees. At-Large Trustees shall be elected to serve for a term of 4 years, and shall not serve for more than 2 terms.

> **3.5.4.1 Limit on Total Tenure**. Trustees may serve for a maximum tenure of 8 years. Trustees elected at an Interim Meeting may serve for a maximum tenure of 8 years from the Annual Meeting following their election. The limitation on tenure shall take priority over a term length for which the Trustee was elected.
>
> **3.5.4.2 Prior Service as Young Physician Trustee.** Periods of service as the young physician trustee shall count as part of the maximum Board of Trustees tenure.
>
> **3.5.4.3 Prior Service as Resident/Fellow Physician Trustee or Medical Student Trustee.** Periods of service as the resident/fellow physician trustee or as the medical student trustee shall not count as part of the maximum Board of Trustees tenure.

3.5.5 Resident/Fellow Physician Trustee. The resident/fellow physician trustee shall serve a term of 2 years and shall not serve for more than 3 terms. If the resident/fellow physician trustee is unable, for any reason, to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected to a term to expire at the conclusion of the second Annual Meeting of the House of Delegates following the meeting at which the resident/fellow physician trustee was elected.

> **3.5.5.1 Cessation of Residency/Fellowship.** The term of the resident/fellow physician trustee shall terminate and the position shall be declared vacant if the trustee should cease to be a resident/fellow physician. If the trustee completes residency or fellowship within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until the completion of the Annual Meeting.

3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on

policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.

3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.

3.5.6.2\ Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

3.5.7 Young Physician Trustee. The young physician trustee shall be elected for a term of 4 years, and shall not serve for more than 2 terms.

3.5.7.1 Limitations. No candidate shall be eligible for election or reelection as the young physician trustee unless, at the time of election, he or she is under 40 years of age or within the first eight years of practice after residency and fellowship training, and is not a resident/fellow physician. A young physician trustee shall be eligible to serve on the Board of Trustees for the full term for which elected, even if during that term the trustee reaches 40 years of age or completes the eighth year of practice after residency and fellowship training.

3.5.8 Public Trustee. A public trustee shall be elected for a term of 4 years, and shall not serve for more than one term. A public trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, except that a public trustee shall not have the right to vote on intra-Board elections. A public trustee shall not be eligible for election as an officer of the Board of Trustees.

……...…

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who

received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

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

6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.1 Members other than the Resident/Fellow Physician Member and Medical Student Member. Members of these Councils other than the

resident/fellow physician and medical student member shall be elected for terms of 4 years.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 3 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.2 Tenure. Members of these Councils may serve no more than 8 years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting.

6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 3-year term. 6.10 Commencement of Term. Members of Councils who are elected by the House of Delegates shall assume office at the close of the meeting at which they are elected.

POLICIES

Policy G-610.010, Nominations

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of nominations to the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should

list candidates in alphabetical order by name only; and (5) nominating speeches for unopposed candidates for office, except for President-elect, should be eliminated.

Policy G-610.020, Rules for AMA Elections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Policy G-610.021, Guiding Principles for House Elections

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

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

Policy G-610.030, Election Process

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

APPENDIX C – Resolutions submitted at the 2019 Annual Meeting

RESOLUTION 603-A-19

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

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

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

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

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

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

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

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

RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns; and be it further

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

RESOLUTION 611-A-19

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

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

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

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

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

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

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

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

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

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

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

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

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

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

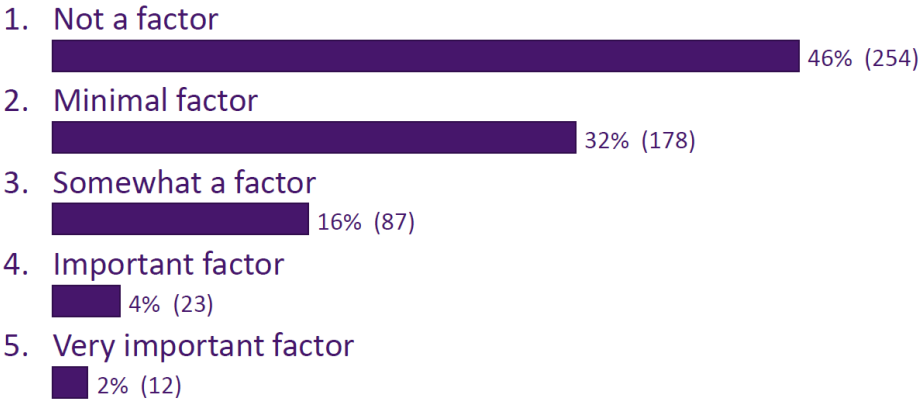
a. Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
b. Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
c. Separating the logistical election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

g. Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.) (Directive to Take Action); and be it further

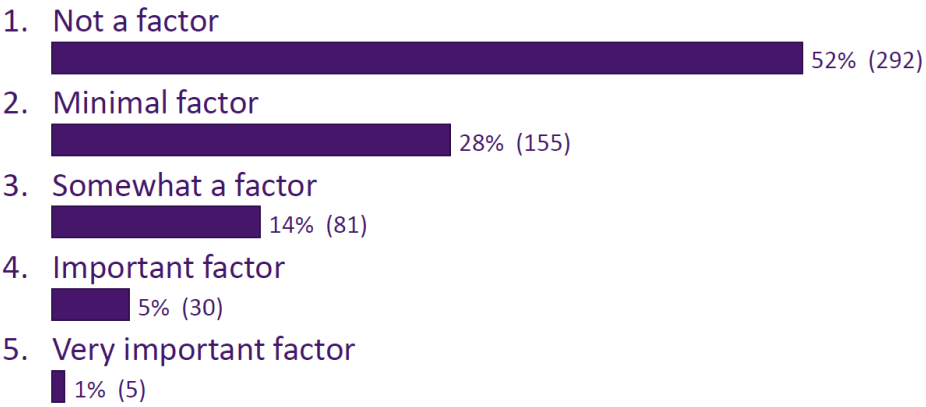
RESOLVED, That the task force report back to the HOD at the 2019 Interim Meeting.

APPENDIX D – Questions and responses from I-19 survey of the House of Delegates

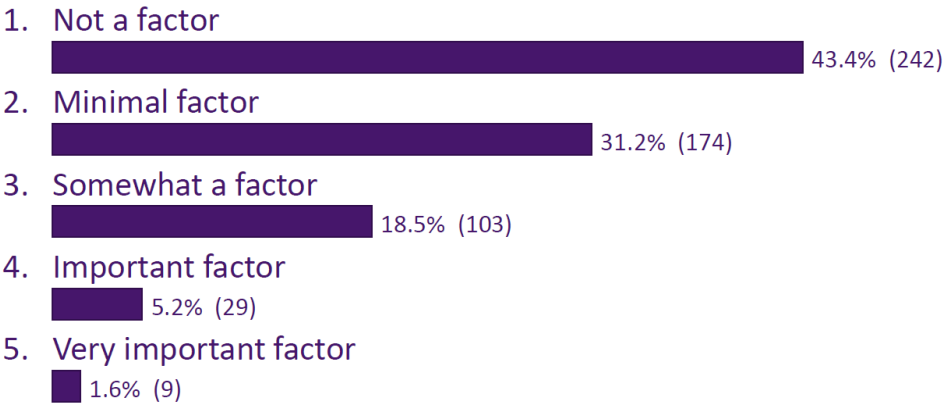
In determining your vote, how much of a factor are campaign brochures in the "Not For Official Business" bag?



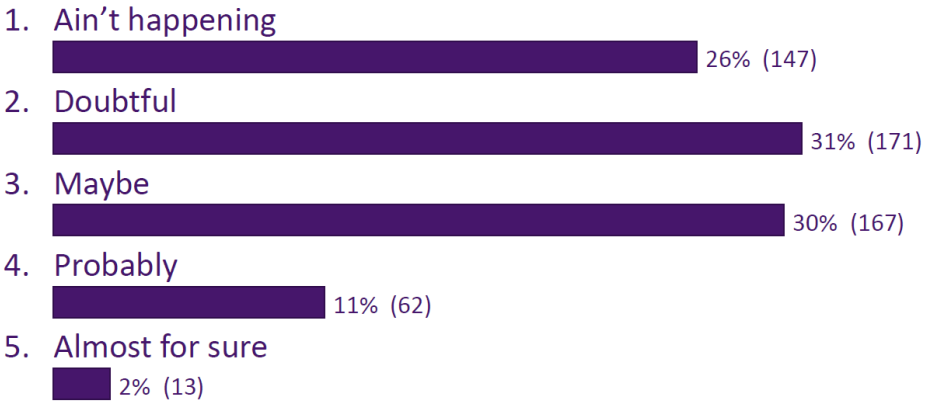
In determining your vote, how much of a factor are campaign brochures mailed to you before the meeting?



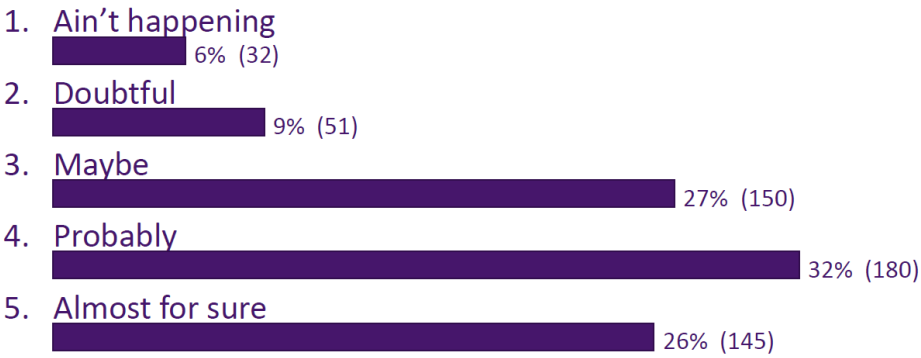
In determining your vote, how much of a factor are campaign materials emailed to you before the meeting?



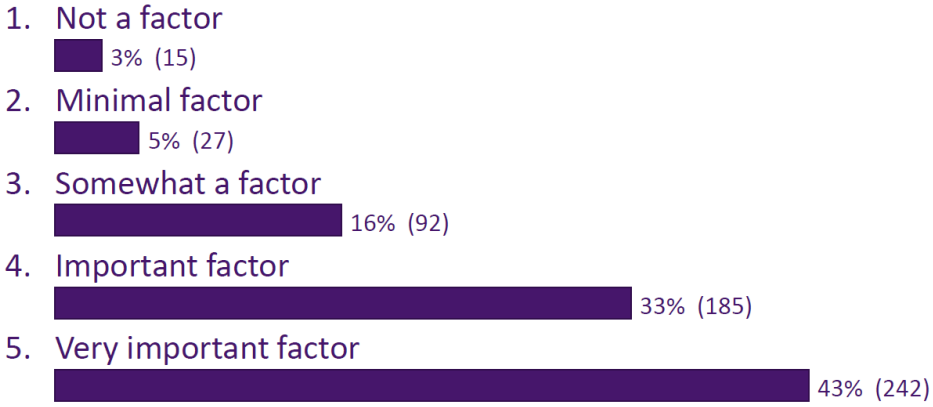
How likely are you to look at candidates' websites?



How likely are you to look at an enhanced AMA Elections website that would include links to the candidates' website and answers to specific questions given to candidates in advance?



In determining your vote, how much of a factor is the interview process?



In determining your vote, how much of a factor are campaign receptions?

1. Not a factor

33.3% (185)
2. Minimal factor

27.5% (153)
3. Somewhat a factor

21.8% (121)
4. Important factor

9.7% (54)
5. Very important factor

7.7% (43)

In determining your vote, how much of a factor are small group dinners and/or gatherings in suites at Interim, State Advocacy and NAC?

1. Not a factor

27% (151)
2. Minimal factor

23% (128)
3. Somewhat a factor

27% (149)
4. Important factor

18% (97)
5. Very important factor

5% (25)

Would you attend a combined candidates party?

1. Ain't happening

4.4% (25)
2. Doubtful

7.6% (43)
3. Maybe

20.6% (116)
4. Probably

29.8% (168)
5. Almost for sure

37.6% (212)

After a seat opens on the BOT or a council, how should the open seat be filled?

1. Open the floor for nominations, give speeches, and hold elections immediately (current process)

2. Hold the seat/s open until the next Interim meeting and elect at that meeting

3. Hold the seat/s open until the next Annual meeting elections

4. Require candidates to vacate their current position at the time of elections, regardless of the outcome

Which statement most accurately reflects the influence your delegation or caucus has on your vote?

1. I receive no guidance from my delegation or caucus regarding elections

2. I get input from my caucus or delegation, but make my own decision

3. I feel somewhat pressured to vote for particular candidates selected by my caucus or delegation

4. I am strongly pressured by my delegation or caucus to vote for certain candidates

5. My vote is mandated by my caucus or delegation

Appendix E - Newly Opened Positions - Options Considered

Three potential solutions for newly created vacancies ("pop-ups") were initially considered: requiring candidates seeking another office to resign their current position; leaving the open seat vacant until the following Annual Meeting; and modifying the procedures for handling new vacancies. Each of these options were discussed at the I-19 Open Forum and were the subject of a question on the survey of the House. Each option received support and opposition, with no consensus reached, but a majority favored some change over the current process. The first two options would require bylaws changes. Ultimately the ETF developed a new fourth option based upon newly available voting technology that allows sequential voting with nearly instantaneous results and rapid ballot preparation which eliminates most of the problems associated with "pop-ups" without necessitating the more radical changes associated with any of the three options presented at I-19. **Below is a discussion of each of the options that were considered, three of which are <u>not</u> recommended.**

Requiring candidates to resign their current positions would address the problematic aspects of these "pop-up" elections. Because all vacancies would be known well in advance, elections could proceed as usual, without additional nominations or speeches, candidates would be known in advance to allow time for proper vetting through the usual interview process, and the possibility of opening a new seat on a council would no longer be a consideration in voting as the seat would be open regardless of the election outcome. To be clear, the incumbent seeking a new position would not resign until the close of the Annual Meeting at which the elections took place, which is when all newly elected officials take office. Questions about the fairness of such a requirement arose, particularly as some officer positions open relatively infrequently as is the case for the offices of Speaker and Vice Speaker, which while elected annually, tend to come open only every four years. In addition, this would potentially mean the tenure of some of our most talented council members (those that feel qualified to seek higher office) would be truncated or alternatively, council members would delay running for higher office until serving their full tenure thus reducing opportunities for new council members and reducing candidates running for higher office. In addition, at the trustee level, this would likely discourage current trustees from running for president-elect "early" and may lead to less contested races for the president-elect position. Some commented in favor of this option, but many found the idea of forcing candidates to resign from current positions in order to run unacceptable. Another concern is whether this requirement would just be implemented for current members of elected councils or would it also apply to members of appointed councils and the Board - either creating a disparity or forcing even more resignations. In the end, the ETF felt this option pressed an unacceptable dichotomy - of the loss of tenured leaders or elected members consistently staying for their full term with less opportunity for new leaders and fewer contested elections.

The second option, namely leaving the vacancy until the following meeting was supported by some during the Open Forum and on the survey. The bylaws treat vacancies arising from the resignation or death of an officeholder differently than election-related vacancies, which suggests it is not the vacancy per se that generates concerns. Twice in the past eleven years a member of the Board of Trustees resigned and created a vacancy lasting several months. For a vacancy that occurred in the spring, the Board did not feel it necessary to appoint a trustee as permitted under AMA's bylaws, and for a vacancy that arose in the fall, neither the Board nor the Committee on Rules and Credentials thought a special election was needed. Vacancies on the elected councils remain unfilled until elections are held at the next Annual Meeting (see Bylaw 6.9.3.1). As a practical matter none of the elected councils has experienced a vacancy in the last 13 years, so it is difficult to judge if a vacancy would undermine the council's effectiveness. Recently 2 members with

unexpired terms on a single council ran for the Board. Would different rules be necessary to handle the situation where multiple seats were vacant vs. a single seat? It was unclear how to handle term and tenure of members elected at the half year and the ETF wanted to keep the Interim Meetings free of elections, so any vacancy would remain for a full year until the next Annual Meeting. Informal discussion with current and past council members suggested that vacancies while not untenable would be undesirable.

The third option discussed, altering the procedures for handling new vacancies, takes two forms. One possibility would be to take nominations immediately after the vacancy is announced, have the nominees make necessary speeches immediately and then move at once to voting. This would address concerns about electioneering and vote trading but further reduces opportunity to vet the candidates. The other possibility would be to call for nominations immediately but to delay voting to the next day, which would currently be Wednesday. This would permit the possibility of interviews, but Tuesday is a full day and the inauguration is Tuesday night, making it unlikely many would interview the candidates. It is also conceivable that a meeting that would otherwise adjourn on Tuesday because the business had been accomplished would have to carry over to the next morning solely for elections. (The task force believes that speedier elections might lead to a Tuesday adjournment; see "Technology" below.) The ETF did not favor moving the date of the main elections from Tuesday and even if moved to Monday with "pop-ups" on Tuesday this would mean elections would be the focus of two HOD sessions contrary to the goal to lessen the distraction from policy deliberation.

The ETF favored a process that encouraged or required candidates to announce their intention to run for potentially newly opened positions but avoided the negatives of the previously discussed options. To accomplish this, members would have to be alerted to potential openings and then allowed to join the campaign. Some would argue that candidates already "announce" that they intend to run if a seat opens just not officially. Formalizing this announcement process would provide greater transparency. Presumably, this would mean more interviews. Likely, these candidates would not go to the same expense and effort of a regular campaign (seen as one of the advantages of being a pop-up). In studying options for use of technology to expedite voting (another specific charge of the ETF), the ETF discovered a novel solution to this issue, as presented in the main body of this report and recommended.

Appendix F - Day of Elections - Options Considered

The following is the ETF discussion regarding moving the day of the elections to an alternative day/time. After the review detailed below, the ETF recommended continuing elections on Tuesday morning while instituting other reforms including electronic voting and the "Election Session."

One of the specific requests of Resolutions 603-A19 and 611-A19 which established the ETF, was to consider moving the day/date of the elections earlier, arguing that this would reduce the number of receptions, interviews, disruption of policy consideration and overall reduce the focus of the meeting away from elections to policy. Current rules specify elections will be on Tuesday (time is determined by Speaker) so a rule change would be required.

Options:

Move elections to Interim - fewer delegates attend. Shorter meeting. Geographic bias in any given year may affect attendance and outcome. Terms of office begin when? Councils and BOT use annual to annual as their planning cycle. This would politicize the interim meeting. Would not correct the concern regarding the "distraction from policy discussion" and may extend the length of Interim meeting.

Saturday voting – little time to meet candidates, particularly lesser known or from small delegations. Vetting process would be truncated or if in-person interviews are to continue, they would likely need to be moved to Friday morning or even Thursday (lengthening the meeting for candidates and interviewers). Would increase reliance on the 2-minute speech before HOD. Less opportunity for interaction with candidates. Potentially less informed voters. Seems to carry many of the disadvantages of "pop ups" which many have spoken against. Saturday is the first day the House convenes and nominations occur this day. Nominations "from the floor" are allowed by our rules - if a candidate is nominated on Saturday and then voting occurs there would be no opportunity to vet that candidate.

Sunday voting – already a very full day. Brief HOD session then reference committee hearings all day. Voting would lengthen the HOD session and delay the start of reference committees; thus, the reports which already take well into the early morning to prepare so they can be reviewed by the delegates would be delayed as well. Little time to vet candidates without moving interviews forward. Receptions would simply start a night earlier.

Monday voting – morning is filled with caucus meetings to review reference committee reports. Moving HOD session start time forward to allow time for elections would reduce time for policy discussion in and among delegations. Monday is already a short day of policy debate (typically 3.5 hrs or less) and provides some insight into remaining business. Some delegates prioritize the elections and might even go home if their candidate is unsuccessful. Would unsuccessful candidates awkwardly continue at the meeting? Would the afternoon be spent with congratulations to the winners (which often takes place at the President's reception Tuesday night), distracting from policy debate? If we move the President's inaugural and dinner to Monday, as has been suggested, the afternoon would need to end by 3 or so (likely meaning minimal or no policy discussion time that day).

Tuesday voting – keep current day but improve the process using technology and rules to expedite the voting including runoffs. Eliminate "pop-up" elections and the associated speeches. Designate an election session early morning with HOD resuming business afterwards lessening the concern

for distraction and interruption of policy debate. Provides maximum time for vetting the candidates. Allows for the President's reception to continue as scheduled on Tuesday night.

Appendix G – Reconciliation of Policies Related to Elections

Policy G-610.010, Nominations

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at their April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only;

Policy G-610.020, Rules for AMA Elections

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

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

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

(4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring

before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls and electronic communication from candidates~~, and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages;

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

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

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

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

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

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

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy G-610.021, Guiding Principles for House Elections

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

(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.

(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.

(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.

(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.

(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.

(6) Service in any AMA leadership position should not assure ascendancy to another leadership position

(7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates.

(8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.

Policy G-610.030, Election Process

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House~~in line to vote~~ at the time appointed to cast their electronic votes~~.for the close of polls~~; and (3) The final vote count of all

secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(JUN-21)

Introduced by: New York

Subject: Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD)

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The ongoing overdose crisis has spared no demographic, professional, or geographic stratum, and although efforts to bring substance use disorder and its treatment out of the shadows have made substantial inroads, outdated thinking, policies, and practices persist; and

Whereas, Opioid-agonist therapy is the standard treatment for opioid use disorder (OUD) and maintenance with methadone or buprenorphine sharply reduces the risks of relapse, overdose, and death, making it possible for patients to regain control of their personal and occupational functions; and

Whereas, Despite the well-documented effectiveness of such MAT (medication assisted treatment), however, MAT for opioid use disorder remains vastly underutilized in the United States and elsewhere; and

Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine concluded that “there is no scientific evidence that justifies withholding medications from OUD patients in any setting” and stated that such practices amount to “denying appropriate medical treatment”; and

Whereas, The American Society of Addiction Medicine recommends that “Healthcare professionals should be offered the full range of evidence-based treatment, including medication for addiction, in whatever setting they receive treatment; and

Whereas, Physicians have a 15-20% lifetime risk of psychiatric or substance use disorder; and

Whereas, Despite the evidence for effectiveness, doctors themselves are often prevented access to opioid agonist therapy due to policies and/or practices of physicians health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers which prevent such access; therefore be it

RESOLVED, That our American Medical Association affirm that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder (New HOD Policy); and be it further

RESOLVED, That our AMA affirm that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including methadone and buprenorphine (New HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD (Directive to Take Action); and be it further

RESOLVED, That our AMA survey physician health programs and state medical boards and report back about whether they allow participants/licensees to use MOUD without punishment, or exclusion from practicing medicine or having to face other adverse consequences. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

Over 15% of physicians have/will have a substance use disorder over their lifetimes. For those whose substance use disorder includes opioid use disorder (OUD), the stigma and fear of being labeled as impaired by the condition, or impaired by treatment with opioid agonist therapy, greatly increases the risk that such docs or students will not enter treatment or that treatment will fail. The AMA has spoken loudly and clearly about the need for more access to MOUD for our patients because we know this affords them the best chance for success and reduces the risk of overdose death.

We cannot let another year go by without speaking loudly for needed access to MOUD for our peers. If we don't consider, discuss and act on this resolution in June 2021, then the risk will be further delays in access to appropriate care for students and physicians with OUD. This results in much higher risk of relapse, loss of license, career, family, and even loss of life by accidental overdose, suicide or death from complications or comorbidities with OUD. Patients who may be receiving their healthcare and in treatment with these physicians would lose access to their doctors if that happened. These possibilities are entirely avoidable if their physicians are successfully provided with effective treatment.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(JUN-21)

Introduced by: American College of Cardiology, American Society of Echocardiography, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, American Society of Nuclear Cardiology

Subject: Sharing Covid-19 Resources

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The severe acute respiratory syndrome coronavirus 2 (COVID-19) has spread globally, causing nearly 3 million deaths worldwide since first appearing in 2019; and

Whereas, We express our condolences to all individuals affected by COVID-19 and their families and friends; and

Whereas, We are grateful for the monumental efforts and sacrifices made by health care professionals, public health workers, research scientists, pharmaceutical companies, government workers, elected officials and others for their continuing contributions in battling this pandemic; and

Whereas, The phenomenal speed with which effective vaccines against this virus was made possible by basic research grants from the National Institutes of Health and other public institutions, further developed and rapidly manufactured in large quantities by investor-owned pharmaceutical companies; and

Whereas, Death and other serious complications of COVID infection are more common in individuals with underlying heart disease, diabetes, hypertension and other chronic illnesses; and

Whereas, The COVID pandemic has unmasked pre-existing severe socioeconomic and racial disparities in the delivery of health care in the United States; and

Whereas, The public health crisis related to the COVID pandemic is even more deadly in many less economically developed countries around the world; and

Whereas, COVID vaccine is soon to be available to all Americans desiring to be vaccinated; and

Whereas, COVID variants continue to appear both in the US and abroad, threatening repeated surges of COVID infections, particularly in those who do not have access to vaccination; and

Whereas, Resurgence of COVID-19 anywhere in the world potentially affects the United States; and

Whereas, There is a moral and ethical imperative to provide effective medical care to all patients regardless of their economic status or citizenship; therefore be it

RESOLVED, That our American Medical Association call for the cooperation of all governments and international agencies to share data, research and resources for the production and distribution of medicines, vaccines and personal protective equipment (Directive to Take Action); and be it further

RESOLVED, That our AMA promote and support efforts to supply COVID vaccines to health care agencies in other parts of the world to be administered to individuals who can't afford them. (Directive to Take Action)

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

Received: 05/03/21

AUTHORS STATEMENT OF PRIORITY

The COVID 19 pandemic is seminal public health threat of the past century, of vital importance to all physicians and all patients worldwide. The AMA should continue and expand its leadership role in this arena, particularly updating its policy on the worldwide, equitable distribution of vaccines and other measures which are critical to combating the pandemic.

RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.
Citation: Res. 408, I-20

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979
1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
Citation: Alt. Res. 404, I-20

World Health Organization H-250.992
The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.
Citation: BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16; Reaffirmed: BOT Rep. 23, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(JUN-21)

Introduced by: American Academy of Pediatrics

Subject: Healthcare Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, "Racism" refers to an organized system, rooted in an ideology of inferiority that categorizes, ranks and differentially allocates societal resources to human population groups[i]; and

Whereas, Racism may or may not be accompanied by prejudice at the individual level[i]; and

Whereas, Explicit bias refers to the attitudes or beliefs we have about a person or group on a conscious level and includes the "-isms" such as racism, sexism, etc held by individuals[ii]; and

Whereas, Implicit or unconscious bias refers to ingrained habits of thought that lead to errors in how we perceive, reason, remember and make decisions and that are unconscious or unintentional and may or may not align with our stated values or beliefs[ii]; and

Whereas, Microaggressions are brief, commonplace, daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward marginalized populations, that implicitly communicate or at least engender hostility"[ii] ; and

Whereas, Microaggressions are very real forms of racism and discrimination, a "persistent daily low hum of racist abuse" that is not minor or micro in how it is experienced[iii]; and

Whereas, Microaggressions generate stresses equal to or worse than overt discrimination for underrepresented minority groups[iv]; and

Whereas, Recent research shows that regular exposure to perceived discrimination of any kind adversely affects the psychological and physical health of the recipients including depression, anxiety, burnout, trauma response, alcohol use, among others[iv,v]; and

Whereas, Patients tend to be in vulnerable states when seeking medical treatment and may be especially susceptible to psychological distress in response to racism or bias; and

Whereas, Racism in any form is especially detrimental when enacted by health care providers; and

Whereas, Many instances of racism and bias will likely stay unrecognized unless an ongoing intentional, reflective, and process-oriented practice is implemented; and

Whereas, Examining racism and bias should be viewed as a growth promoting, educational opportunity that has the potential to improve individual interactions and system level practices; therefore be it

RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders

should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
  - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
  - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/07/21

AUTHORS STATEMENT OF PRIORITY

Racism, or discrimination based on race or ethnicity is responsible for increasing disparities in physical and mental health among Black, Indigenous, and people of color. We feel that this resolution is a top priority for this meeting as it will provide policy for our AMA's new three-year roadmap to embed racial justice and advance health equity within the AMA and our health care system.

[i] Bonilla-Silva E. Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review*. 1996;62(3):465–480.
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: AMA Resident/Fellow Councilor Term Limits

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Based on a review of the foundational reports leading to the development of resident/fellow Council and BOT positions, the purpose of these roles is to maintain a resident voice in these bodies and to allow for residents and fellows to both gain experience in the election process and contribute meaningfully to practices of the Councils and BOT; and

Whereas, BOT Report A at the 1976 AMA Annual Convention, which codified resident and non-voting medical student representation on the Councils with three-year term lengths and a maximum three-term limit for the Council on Medical Education (CME), Council on Medical Service (CMS), Council on Scientific Affairs, and CLRPD; and

Whereas, Starting at the 1991 Annual Meeting, AMA House of Delegates Resolution 202 "Leadership Opportunities in the American Medical Association" called for a review of the AMA Board and Councils to increase the rate of involvement of, "various demographic segments of the AMA physician population in AMA leadership" and the subsequent study period yielded a survey of AMA members showing, "57% favored reducing the maximum tenure of Council members"; and

Whereas, During the 1996 Interim Meeting of the AMA, the Council on Long Range Planning and Development (CLRPD) presented Report 2 "Terms of Service of AMA Councils" which discussed some of the history of Council term lengths and presented arguments for and against one-, three-, five-, and seven-year terms for AMA Councils, considering "(a) the frequency of campaigns for Council positions, (b) the responsiveness of Council members to the AMA membership, the House and the Board, (c) opportunities to replace Council members whose performance is problematic, and (d) compatibility with the maximum total number of years that individuals can serve on each Council"; and

Whereas, The CLRPD I-96 Report 2 noted that shorter terms would lead to increased member responsiveness and ease in removal of ineffective Council members, but increase time and cost devoted to campaigns, while shorter terms would be better suited for task-oriented Councils such as the Council on Legislation (COL); and

Whereas, The RFS has concerns that three-year resident/fellow Council positions would disproportionately inhibit members of specialties with shorter residency training periods from being represented, including Internal Medicine, Emergency Medicine, Pediatrics and Family Medicine; and

Whereas, Due to current term lengths residents/fellows in longer training programs are unintentionally favored for Council positions; and

Whereas, From 2005-2019 only five residents in three-year residencies without subsequent fellowship positions served as residents on AMA Councils over this 15-year period; and

Whereas, Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 48 seats (40.0%) were held by residents in three-year residencies, though only 13 seats (10.8%) were held by residents in three-year residencies without subsequent fellowship positions despite 57% of residents matching to a specialty with only 3 years of training; and

Whereas, Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 65.8% were held by residents either in training programs of 5 or more years or went on to fellowship training totaling 5 or more years during their term; and

Whereas, BOT Report W from 1983 titled "Resident Member of the AMA Board of Trustees" was adopted allowing for the creation of a resident Trustee with a term length of two years and a maximum three-term limit; and

Whereas, The Resident Member of the Board of Trustees has been an effective member of the Board of Trustees despite a term of only two years; and

Whereas, Residents with shorter training periods are disproportionately underrepresented in elected and appointment Council positions thus creating a disparity in representation between primary care residents and specialty-trained ones; and

Whereas, Two-year terms would allow for more opportunities for residents at all training programs, especially those in 3 or 4 year residencies to be represented on AMA councils; therefore be it

RESOLVED, That our American Medical Association amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.5 Council on Ethical and Judicial Affairs.

6.5.7 Term.

6.5.7.2 Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2~~3~~ years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2~~3~~-year term. (Modify Bylaws) and be it further

RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.6 Council on Long Range Planning and Development.

6.6.3 Term.

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 2~~3~~ years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.5 Vacancies.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2~~3~~-year term. (Modify Bylaws) and be it further

RESOLVED, That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 2~~3~~ years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.3 Vacancies.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 23-year term. (Modify Bylaws)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The Council on Constitution and Bylaws has indicated support for this policy change, but it requires approval by the HOD. This is crucial to the proper functioning of our RFS leadership and affects elections at this HOD and RFS elections at Interim. Residents and fellows make decisions about leadership and involvement based on time left in training and this change will directly affect our members immediately.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The average age at completion of medical training in the United States is approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and

Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50% drop from the early 20s to late 30s[5]; and

Whereas, Female physicians have a chance of infertility that is twice that of the general population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and

Whereas, The demands of residency increase the risk of pregnancy complications, with a higher rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth restriction among female residents[6–8]; and

Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during training[9] and have concerns about workplace support,[10] which may deter medical students from choosing a career in a surgical or other field with longer and demanding training; and

Whereas, Approximately one third of program directors have reported discouraging pregnancy among residents in surgical training programs[10]; and

Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in addition to requiring timely injection of ovarian stimulation medications and numerous outpatient visits for cycle monitoring and egg retrieval[13]; and

Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for several years[14]; therefore be it

RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (Directive to Take Action)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. This policy applies to current and all future physician trainees.

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RELEVANT AMA POLICY

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Patient autonomy is one of the basic tenets of medical ethics and includes the patient's right to accept, modify, and refuse treatment[1,2]; and

Whereas, A patient desiring treatment must provide informed consent which can only be given after being informed of their diagnosis, if known, the nature and purpose of any recommended interventions, and the anticipated risks, benefits, and consequences of all options[3–5]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) defines informed consent as "a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care"[6]; and

Whereas, A patient's provider is legally and ethically obligated to inform patients as part of the consent process any party who can be reasonably anticipated to be part in their care team including but not limited to residents, nurses, students, and allied health professionals[3,7]; and

Whereas, Teaching hospitals historically used the generalized consent form as permission to perform exams of the genital areas, including for educational purposes, without deliberately informing patients of opportunities to limit how any care teams or their members could be involved in their care experience[4,8–14]; and

Whereas, In the 1980s, women vocalized demands to be asked for additional explicit consent prior to undergoing educational pelvic exams in the operating room and indicated that doing so without this consent constituted physical assault[15]; and

Whereas, Surveys conducted in 2003 in Philadelphia and 2005 in Oklahoma found medical students were still conducting educational pelvic and rectal exams on anesthetized or unconscious patients without having obtained prior consent to do so[12,16,17]; and

Whereas, Educational pelvic exams were historically performed on patients under anesthesia in operating rooms without explicit patient consent, including by medical students not directly involved or not reasonably anticipating to be involved with the patient's ongoing care and when the patient's surgical indications did not warrant a pelvic exam[18]; and

Whereas, Varying attitudes on educating medical students on invasive exams compounded with pressures on students to achieve high academic and clinical marks may contribute to erosion of consideration for scenarios when additional patient consent is indicated[16,19–24]; and

Whereas, The Association of American Medical Colleges (AAMC) and ACOG both emphasize that pelvic exams performed under anesthesia for educational purposes should only be done with a patient's informed consent prior to conducting the exam[4,24]; and

Whereas, Various states have passed legislation outlawing educational pelvic exams and/or pelvic exams in general, potentially even when indicated as part of a procedure, on a woman who is anesthetized or unconscious without prior consent to specifically do so[14,25–32]; and

Whereas, The Joint Commission maintains that patients may decline participating in elements of clinical training programs, such as working with medical students[12,33]; and

Whereas, The AMA Code of Medical Ethics states that patient "participation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients' (or surrogates') refusal of care by a trainee should be respected in keeping with ethics guidance."[34]; and

Whereas, While patients are often open to learner involvement in their care, they may deem scrutiny of more private body parts, particularly when solely for educational purposes, to warrant specific consent beyond the level provided for general care and treatment[15,35–37]; and

Whereas, Use of professional standardized patients who teach female pelvic, male genitourinary, and rectal exams have already demonstrated significant value in medical education and further highlight the unnecessary nature of educational genital exams performed without explicit patient consent[38–40]; therefore be it

RESOLVED, That our American Medical Association oppose performing physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior informed consent to do so (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm policy H-320.951, "AMA Opposition to "Procedure-Specific" Informed Consent." (Reaffirm HOD Policy)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

This topic has once again made the news in the last year and is a thorn in the side of our profession. To ensure the continued trust in our profession by our patients and therefore by the public at large, the AMA needs to make a clear statement that unnecessary pelvic exams on sedated patients without their consent is not appropriate. We must not waste the good will and trust we have garnered from the public. This should not be controversial and is already supported by ACOG.

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RELEVANT AMA POLICY

Code of Medical Ethics
2.1.1 Informed Consent
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

2.1.6 Substitution of Surgeon
Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute. A surgeon who allows a substitute to conduct a medical procedure on his or her patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.

When one or more other appropriately trained health care professionals will participate in performing a surgical intervention, the surgeon has an ethical responsibility to:
(a) Notify the patient (or surrogate if the patient lacks decision-making capacity) that others will participate, including whether they will do so under the physician's personal supervision or not.
(b) Obtain the patient's or surrogate's informed consent for the intervention, in keeping with ethical and legal guidelines.

2.3.6 Surgical Co-Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

7.1.2 Informed Consent in Research
Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will.

Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.

A valid consent process includes:
(a) Ascertaining that the individual has decision-making capacity.
(b) Reviewing the process and any materials to ensure that it is understandable to the study population.
(c) Disclosing:
(i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
(ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
(iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
(iv) the likelihood of therapeutic or other direct benefit for the participant;
(v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
(vi) the nature of the research plan and implications for the participant;
(vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.
(d) Answering questions the prospective participant has.
(e) Refraining from persuading the individual to enroll.
(f) Avoiding encouraging unrealistic expectations.
(g) Documenting the individual's voluntary consent to participate.
Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:
(h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.
(i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
(j) There is potential for the individual to benefit from the study.
In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

9.2.1 Medical Student Involvement in Patient Care
Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment. All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should: (a) Convey to the patient the benefits of having medical students participate in their care. (b) Inform the patients about the identity and training status of individuals involved

in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients. (c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated. (d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity. (e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2 Resident & Fellow Physicians' Involvement in Patient Care
Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals. Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should: (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow. (b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients. (c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients. Physicians involved in training residents and fellows should: (d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity. (e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility. (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise. (g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

9.2.5 Medical Students Practicing Clinical Skills on Fellow Students
Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as "patients" are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students' privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:
(a) Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
(b) Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.
(c) Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.

(d) Allow students the choice of whether to participate prior to entering the classroom.
(e) Never require that students provide a reason for their unwillingness to participate.
(f) Never penalize students for refusing to participate. Instructors must refrain from evaluating students' overall performance based on their willingness to volunteer as "patients."
Citation: Issued 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951
Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.
Citation: Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.
(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.
(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(JUN-21)

Introduced by: Virginia, New Jersey, District of Columbia, Louisiana, American Association of Clinical Urologists, American Urological Association, Maryland

Subject: Nonconsensual Audio/Video Recording at Medical Encounters

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Fifteen percent of physician-patient visits may be unknowingly recorded with the ubiquitous use of smartphones and other technologies; and

Whereas, Physician malpractice defense attorneys and insurers are anticipating future litigation where patients have recorded telehealth visits without the physicians knowledge or consent; and

Whereas, Thirty-nine states and the District of Columbia conform to a single-party consent rule for recording a conversation between two parties. Eleven states (California, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Oregon, Pennsylvania, and Washington) require consent of both parties[1]; and

Whereas, Audio/video recording of a medical encounter may be of benefit for a patient to recall the pertinent issues and instructions given. Conversely, a covert recording made without the physician or patient's knowledge may erode trust and harm the physician-patient relationship; therefore be it

RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks the AMA to develop policy on nonconsensual audio/video recordings during medical encounters. Studies already show this is occurring at significant rates and will likely increase with the expansion of telehealth during and post-pandemic. Additionally, malpractice defense attorneys are anticipating litigation where patients have recorded telehealth visits without the physician's consent or knowledge. The AMA should take a lead role in developing guidelines for both physicians and their patients on this subject.

References:
[1] Elwyn G, Barr PJ, Castaldo M. Can Patients Make Recordings of Medical Encounters? What Does the Law Say? JAMA. 2017;318(6):513–514. doi:10.1001/jama.2017.7511

RELEVANT AMA POLICY

E-3.1.3. Audio or Visual Recording Patients for Education in Health Care
Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.
To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:
(a) Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
(b) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
(c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
(i) about the purpose of recording, the intended audience(s), and the expected distribution;
(ii) about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
(iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patients care;
(iv) that the patient may withdraw consent at any time and if so, what will be done with the recording;
(v) that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
(d) Ensure that the patient has had opportunity to discuss concerns before and after recording.
(e) Obtain consent from a patient (or the authorized decision maker):
(i) prior to recording whenever possible; or
(ii) before use for educational purposes when consent could not be obtained prior to recording.
(f) Respect the decision of a patient to withdraw consent.
(g) Seek assent from the patient for participation in addition to consent by the patients parent or guardian when participation by a minor patient is unavoidable.
(h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the films educational content and value.
(i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
(j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records.
AMA Principles of Medical Ethics: I,IV,V,VIII
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
E-3.1.4 Audio or Visual Recording of Patients for Public Education
Audio and/or visual recording of patient care for public broadcast is one way to help educate the public about health care. However, no matter what medium is used, such recording poses challenges for protecting patient autonomy, privacy, and confidentiality. Filming cannot benefit a

patient medically and may cause harm. As advocates for their patients, physicians have an obligation to protect patient interests and ensure that professional standards are upheld. Physicians also have a responsibility to ensure that information conveyed to the public is complete and accurate (including the risks, benefits, and alternatives of treatments).
Physicians involved in recording patients for public broadcast should:
(a) Participate in institutional review of requests to record patient interactions.
(b) Require that persons present for recording purposes who are not members of the health care team:
(i) minimize third-party exposure to the patients care; and
(ii) adhere to medical standards of privacy and confidentiality.
(c) Encourage recording personnel to engage medical specialty societies or other sources of independent expert review in assessing the accuracy of the product.
(d) Refuse to participate in programs that foster misperceptions or are otherwise misleading.
(e) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
(f) Inform a patient (or authorized decision maker) who is to be recorded:
(i) about the purpose for which patient encounters with physicians or other health care professionals will be recorded;
(ii) about the intended audience(s);
(iii) that the patient may withdraw consent at any time prior to recording and up to an agreed on time before the completed recording is publicly broadcast, and if so, what will be done with the recording;
(iv) that at any time the patient has the right to have recording stopped and recording personnel removed from the area;
(v) whether the patient will be allowed to review the recording before broadcast and the degree to which the patient may edit the final product; and
(vi) whether the physician was compensated for his participation and the terms of that compensation.
(g) Ensure that the patient has had the opportunity to address concerns before and after recording.
(h) Ensure that the patients consent is obtained by a disinterested third party not involved with the production team to avoid potential conflict of interest.
(i) Request that recording be stopped and recording personnel removed if the physician (or other person involved in the patients care) perceives that recording may jeopardize patient care.
(j) Ensure that the care they provide and the advice they give to patients regarding participation in recording is not influenced by potential financial gain or promotional benefit to themselves, their patients, or the health care institution.
(k) Remind patients and colleagues that recording creates a permanent record and may in some instances be considered part of the medical record.

AMA Principles of Medical Ethics: I,IV,VII,VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(JUN-21)

Introduced by: Pennsylvania

Subject: Organ Transplant Equity for Persons with Disabilities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, People with Intellectual and developmental disabilities (IDD) still face discrimination in access of care, specifically regarding barriers of access to transplant surgery, despite federal and local guidelines which protect against discrimination on the basis of disability; and

Whereas, Transplant centers and medical professionals are unaware or noncompliant with clauses of the Americans with Disabilities Act, Rehabilitation Act, and Affordable Care Act prohibiting discrimination against people with disabilities as is applied to the organ transplant process; and

Whereas, A 2004 survey found that only 52 percent of people with disabilities who requested a referral to a specialist regarding an organ transplant evaluation actually received a referral, while 35 percent of those “for whom a transplant had been suggested” never even received an evaluation; and

Whereas, A 2008 survey of pediatric transplant centers found that 43 percent always or usually consider intellectual disabilities an absolute or relative contraindication to transplant due to assumptions and that in some cases, organ transplant centers may categorically refuse to evaluate a patient with a disability as a candidate for transplant; and

Whereas, Throughout their medical education, Health, Oral Health, and Vision Health providers receive limited training on the special needs of people with IDD related to common problems and delivery of services, and patients report feeling that physicians generally have little understanding of living with a disability; and

Whereas, If a person has a disability that is unrelated to the reason a person needs an organ transplant, the disability will generally have little or no impact on the likelihood of the transplant being successful and making assumptions regarding post-transplant quality of life for people with IDD violates AMA ethics; and

Whereas, Congress established the need for an organization, the Organ Procurement and Transplant Network (OPTN), to facilitate the organ transplantation system across the many transplant centers and sources of organ donors in an efficient manner. The effective guidelines for organ allocation do not include disability status in non-discrimination section 5.4.A; and

Whereas, Titles II and III of the Americans with Disabilities Act (ADA) prohibit discrimination against people with disabilities in all programs, activities and services of public entities and prohibit private places of public accommodation from discriminating against people with disabilities; and

Whereas, Section 504 of the Rehabilitation Act of 1973 prohibits federally funded programs including hospitals from denying qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits, denying access to programs, services, benefits or opportunities to participate as a result of physical barriers, and denying employment opportunities they are otherwise entitled or qualified; and

Whereas, Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities and ensures physical access for individuals with disabilities to healthcare facilities and appropriate communication technology to assist persons who are visually or hearing impaired; therefore be it

RESOLVED, That our American Medical Association support equitable inclusion of people with intellectual and developmental disabilities (IDD) in eligibility for transplant surgery (New HOD Policy); and be it further

RESOLVED, That our AMA support individuals with IDD having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further

RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their nondiscrimination policy under the National Organ Transplant Act of 1984 (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution recognizes that, although there are existing laws prohibiting discrimination on basis of disability, there is evidence to suggest that people with disabilities remain statistically less likely to receive consultation regarding -- and access to -- organ transplantation. Furthermore, although there is evidence to suggest that those with intellectual disabilities have similar outcomes after transplantation, there may be misperceptions to the contrary within the healthcare system. This resolution aims to have our AMA highlight this discrepancy between law and practice. We feel this is timely because this not only provides an avenue for our organization to advocate for those with disability, but to once again bring to the forefront the challenge of sufficient organ procurement in our nation.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(JUN-21)

Introduced by: Illinois

Subject: Supporting Women and Underrepresented Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Racial bias within the healthcare system is a major factor in current healthcare disparities within the United States; and

Whereas, In recent years, there has been a stagnation of the percentage of women and minorities pursuing competitive fellowships within internal medicine; and

Whereas, In academic surgery, 19% are female, and women are less likely to be full professors when controlling for age as well as academic and clinical productivity; and

Whereas, Hispanic and African-American are more underrepresented in clinical academic medicine in current times than they were in 1990; and

Whereas, Women in academic surgery hold fewer positions of leadership on both the departmental and national level; and

Whereas, Chairs of academic surgery departments often rely heavily on internal hires and trusted networks instead of publicly posting positions, while simultaneously reporting difficulty in recruiting women and underrepresented minority applicants for those positions; therefore, be it

RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; (Directive to Take Action) and be it further

RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields:

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce
Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and take active measures to support medical students who identify with groups underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics:

1. Identify with group(s) underrepresented and disadvantaged in medicine
2. Are from medically underserved areas
3. Are first generation college graduates

as a mechanism to create more exposure to leadership and networking opportunities for these students. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents an issue that is timely, urgent, and high priority.
The link between bias – both implicit and overt – and healthcare disparities has been well documented. Ensuring that individuals who are typically underrepresented in the medical field have support and opportunities throughout their medical education and training to pursue a range of specialties and leadership positions is critical to helping promote equity across the healthcare spectrum.

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19;

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19;

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies

articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
Citation: (Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

Diversity in Medical Education H-350.970
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.
Citation: (BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4.Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(JUN-21)

Introduced by: Georgia

Subject: Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, In many states, when a physician retires, has been suspended, or has their license is revoked, patients often have no warning that their physician's office is closed and no ability to obtain their medical records to transfer their care to another physician; and

Whereas, Laws in many states provides that it is the physician who not only owns the patient's medical records, but also possesses the decision-making ability regarding sharing the records once a patient consents or signs a confidential waiver, except in cases of a subpoena or court order; and

Whereas, Patients who are aware of their physician retiring are more likely to obtain their medical records upon request, than those patients who have had their physician suspended or revoked; and

Whereas, The inability of patients to obtain their medical records could be detrimental for chronically ill patients who will need frequent follow-ups, creating increased hospitalizations with increased costs that may have been avoidable; and

Whereas, There is no AMA policy clearly defining the suspended or revoked physician's responsibilities for patients with their medical records; and

Whereas, For example, the Texas Medical Board has implemented a policy requiring a suspended or revoked Texas physician to appoint a board-approved custodian tasked with notifying patients within 30 days for the purpose of giving them their medical records; therefore be it

RESOLVED, That the Council on Ethical and Judicial Affairs be requested to examine E-3.3.1, "Management of Medical Records," with regards to physicians whose license has been suspended or revoked and prepare a report to the 2021 Interim Meeting, including guidance for timely transfer of patient records to the patient or a state medical board-approved custodian. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The mental and emotional toll of the COVID-19 pandemic has led to increases in substance use disorder that may lead to disciplinary action by medical boards across the country in the coming months. Many states currently have no system for ensuring that medical records are available to a patient where their physician's license has been suspended or revoked and the AMA has no current policy on what should happen to medical records in these instances. This harms these patients because it can lead to a delay in care or a need to repeat diagnostic exams or testing, which can increase costs. It is imperative that a solution is developed now so that ensures that patients can retrieve these records in order to find a new physician to continue their care and a delay in implementing this policy will negatively affect patients and public health in general. The AMA is most appropriate for advocating for this change given the lack of policy in states across the country.

RELEVANT AMA POLICY

3.3.1 Management of Medical Records
Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.
In keeping with the professional responsibility to safeguard the confidentiality of patientspersonal information, physicians have an ethical obligation to manage medical records appropriately.
This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patients authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.
To manage medical records responsibly, physicians (or the individual responsible for the practices medical records) should:
(a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patientsmedical records by unauthorized staff.
(b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
(i) immunization records, which should be kept indefinitely;
(ii) records of significant health events or conditions and interventions that could be expected to have a bearing on the patients future health care needs, such as records of chemotherapy.
(c) Make the medical record available:
(i) as requested or authorized by the patient (or the patients authorized representative);
(ii) to the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death);
(iii) as otherwise required by law.
(d) Never refuse to transfer the record on request by the patient or the patients authorized representative, for any reason.
(e) Charge a reasonable fee (if any) for the cost of transferring the record.
(f) Appropriately store records not transferred to the patients current physician.
(g) Notify the patient about how to access the stored record and for how long the record will be available.
(h) Ensure that records that are to be discarded are destroyed to protect confidentiality.
AMA Principles of Medical Ethics: IV,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(JUN-21)

Introduced by: Minority Affairs Section

Subject: Truth, Reconciliation, and Healing in Medicine and Medical Education

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Historical examination of AMA practices and policies have not always served to further equity and justice, but rather categorically exclude or severely limit opportunities for physicians based on race, ethnicity, gender, sexual orientation, capacity, and country of origin, and perpetuate intergenerational harm to historically marginalized and minoritized communities[1-4]; and

Whereas, AMA archives chronicle decisions by leadership primarily rooted in racism and white supremacy, which have contributed to the systems of power and oppression that structured the realities of health inequities among women, LGBTQ+, Jewish, Black, Indigenous, Latinx, and Asian populations then, and which persist today[5-14]; and

Whereas, The 1910 "Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching" (a.k.a. "The Flexner Report") commissioned by the AMA's Council on Medical Education recommended the closure of five out of the seven historically Black college or university (HBCU) affiliated medical schools existing at the time and described the role of Black physicians as sanitarians and hygienists to "protect" white people from "Black diseases" [15,16]; and

Whereas, A recent study in *JAMA Network Open* found that the five HBCU-affiliated schools closed as a result of the Flexner Report's recommendations would have produced an additional 27,773 Black medical graduates in the years between their closure and 2019, increasing the number of Black medical graduates by 29% in 2019 alone[17]; and

Whereas, The AMA has recently taken significant steps to achieve optimal health for all in the areas of scholarship, research, philanthropy, advocacy, healthcare delivery, and practice through the adoption and implementation of policies, processes, and programs that center equity and antiracism, such as the founding of the AMA Center for Health Equity, recognizing racism as a public health threat, characterizing race as a social construct, reconsidering the clinical application of race, and acknowledging the way communities are policed is a social determinant of health, among others[18]; and

Whereas, In May 2021, the AMA Center for Health Equity released its three-year organizational strategic action plan to embed racial justice and advance health equity within the AMA and across medicine, including "fostering pathways for truth, racial healing, reconciliation and transformation for AMA's past" through restorative justice[19,20]; therefore be it

RESOLVED, That our American Medical Association establish a combined external and internal task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY:

As an extension of the AMA Center for Health Equity strategic action plan, this resolution calls for the creation of a task force to strengthen organizational capacity to advance and operationalize equity from within and across medicine through restorative justice. The task force will guide our AMA's transformational work, including historical identification of and accountability for past harmful policies, processes, and archival silence, to promote truth, reconciliation, and healing.

Establishing a task force of this nature is an actionable directive that expands upon and supports ongoing initiatives to dismantle structural racism while presenting an opportunity to evaluate the role of institutions in maintaining these structures.

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RELEVANT AMA POLICY

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.
Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19

Improving Healthcare of Hispanic Populations in the United States H-350.975
It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.
(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.
(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.
(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.
(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.
(6) Promote research into effectiveness of Hispanic health education methods.
(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
Citation: (CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-

designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
Citation: BOT Action in response to referred for decision Res. 602, I-15;

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
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Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

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(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role

of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19;

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.
Citation: Res. 405, A-18

Guiding Principles for Eliminating Racial and Ethic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities; 3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and 4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.
Citation: (Res. 409, A-09; Appended: Res. 416, A-11)

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define serious injuries for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Citation: Res. 406, A-16; Modified: BOT Rep. 28, A-18

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;

(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
Citation: CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.
Citation: Res. 914, I-07; Modified: BOT Rep. 22, 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.
Citation: Res. 001, A-18

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges 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 have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes 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.
3. Our AMA will 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.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages 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.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20

Plan for Continued Progress Toward Health Equity D-180.981
1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.
Citation: BOT Rep. 33, A-18;

AMA Support of American Indian Health Career Opportunities H-350.981
AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)

Racial Essentialism in Medicine D-350.981
1. Our AMA recognizes 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.
2. Our AMA encourages 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.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. Our AMA will 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.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.
Citation: Res. 10, I-20;

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages 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: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends 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.
Citation: Res. 11, I-20

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19;

Diversity in the Physician Workforce and Access to Care D-200.982
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.
Citation: CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16;

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
Citation: CMS Rep. 7, I-20

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4.encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Citation: Res. 307, A-09; Appended: Res. 955, I-17

Alignment of Accreditation Across the Medical Education Continuum H-295.862
1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.
3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.
4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.
5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.
6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.
7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
Citation: (CME Rep. 4, A-14; Appended: CME Rep. 10, A-15)

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
1. Our AMA: (a) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (b) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (c) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with: (a) the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; and (b) the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
Citation: Res. 910, I-16; Appended: Res. 410, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(JUN-21)

Introduced by: Young Physicians Section

Subject: Increasing Public Umbilical Cord Blood Donations in Transplant Centers

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Allogeneic stem cell transplants continue to save lives, reaching over 20,000 procedures per year in the United States[1]; and

Whereas, Allogeneic stem cell therapy can only save lives in patients matched with a donor; and

Whereas, Umbilical cord blood stem cells offer clinical advantages over traditional stem cell transplants in select scenarios[2]; and

Whereas, Umbilical cord blood transplants increase the ethnic diversity of patients eligible for transplant[3]; and

Whereas, The American Society for Transplantation and Cellular Therapy[4], the American College of Obstetricians and Gynecologists[5], and the American Academy of Pediatrics[6] all support public (altruistic) donation of cord blood when possible; and

Whereas, Public donation of cord blood is difficult if the birthing hospital does not support public cord donation; and

Whereas, Very few hospitals support in-house public cord blood donation infrastructure - only two hospitals in Ohio, and three each in New York and Massachusetts[7]; and

Whereas, Many hospitals which provide comprehensive care including both childbirths and stem cell transplants are notably absent from these lists; therefore be it

RESOLVED, That our American Medical Association encourage all hospitals with obstetrics programs to make available to patients and reduce barriers to public (altruistic) umbilical cord blood donation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the availability of altruistic cord blood donations in all states. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for support for tying an option for public cord blood donation on Labor and Delivery to transplant programs quality metrics at the same hospital. Though this is important, this impacts a small number of physicians and is not a time-sensitive issue. Specialty organizations may also be suited to making this push for policy. Therefore, we feel this is a low priority resolution.

References:
1. Center for International Blood and Marrow Transplant Research, Health Resources & Services Administration, US Department of Health and Human Services. Transplant Activity Report Covering 2012-2016: Table 1. Total number of HCTs performed in the United States and reported to CIBMTR* 2012-2016. 26 Feb 2018. Accessed at https://bloodcell.transplant.hrsa.gov/research/transplant_data/transplant_activity_report/summary-total_tx_by_year.pdf
2. The Leukemia & Lymphoma Society. Cord Blood Stem Cell Transplantation. 2 Aug 2007. Available at https://www.lls.org/sites/default/files/file_assets/cordbloodstemcelltransplantation.pdf.
3. Be the Match. Cord blood donation frequently asked questions. Accessed 22 Apr 2019. Available at https://bethematch.org/support-the-cause/donate-cord-blood/cord-blood-faqs/.
4. American Society for Blood and Marrow Transplantation. ASBMT POSITION STATEMENT Collection and Preservation of Cord Blood for Personal Use. Biology of Blood and Marrow Transplantation 14:364 (2008). Available at https://higherlogicdownload.s3.amazonaws.com/ASBMT/43a1f41f-55cb-4c97-9e78-c03e867db505/UploadedImages/ASBMT_Cord_Blood_Position_Statement.pdf.
5. American College of Obstetricians and Gynecology. ACOG Committee Opinion Number 771. 21 Feb 2019. Available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Genetics/Umbilical-Cord-Blood-Banking.
6. Section on Hematology/Oncology and Section on Allergy/Immunology, American Academy of Pediatrics. Cord Blood Banking for Potential Future Transplantation. Pediatrics Jan 2007, 119 (1) 161-164; DOI: 10.1542/peds.2006-2900. Available at https://pediatrics.aappublications.org/content/pediatrics/119/1/165.full.pdf.
7. Be the Match. List of Participating Hospitals. Accessed 22 Apr 2019. Available at https://bethematch.org/support-the-cause/donate-cord-blood/how-to-donate-cord-blood/participating-hospitals/.

RELEVANT AMA POLICY

Code of Medical Ethics. 6.1.5 Umbilical Cord Blood Banking

Transplants of umbilical cord blood have been recommended or performed to treat a variety of conditions. Cord blood is also a potential source of stem and progenitor cells with possible therapeutic applications. Nonetheless, collection and storage of cord blood raise ethical concerns with regard to patient safety, autonomy, and potential for conflict of interest. In addition, storage of umbilical cord blood in private as opposed to public banks can raise concerns about access to cord blood for transplantation.

Physicians who provide obstetrical care should be prepared to inform pregnant women of the various options regarding cord blood donation or storage and the potential uses of donated samples.

Physicians who participate in collecting umbilical cord blood for storage should:

(a) Ensure that collection procedures do not interfere with standard delivery practices or the safety of a newborn or the mother.

(b) Obtain informed consent for the collection of umbilical cord blood stem cells before the onset of labor whenever feasible. Physicians should disclose their ties to cord blood banks, public or private, as part of the informed consent process.

(c) Decline financial or other inducements for providing samples to cord blood banks.

(d) Encourage women who wish to donate umbilical cord blood to donate to a public bank if one is available when there is low risk of predisposition to a condition for which umbilical cord blood cells are therapeutically indicated:

(i) in view of the cost of private banking and limited likelihood of use;

(ii) to help increase availability of stem cells for transplantation.

(e) Discuss the option of private banking of umbilical cord blood when there is a family predisposition to a condition for which umbilical cord stem cells are therapeutically indicated.

(f) Continue to monitor ongoing research into the safety and effectiveness of various methods of cord blood collection and use.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(JUN-21)

Introduced by: Medical Student Section

Subject: Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, Natural hair can be defined as a hair texture that is tightly coiled or tightly curled as well as hairstyles that include locs, cornrows, twists, braids, Bantu knots, fades, Afros, and/or the right to keep hair in an uncut or untrimmed manner [1]; and

Whereas, Cultural headwear refers to head or hair coverings (i.e. hijabs, turbans) worn for cultural purposes and serves as a way to express values of a demographic group or particular society for religious, spiritual, or gender identification [2]; and

Whereas, Discrimination and/or restrictions targeting hairstyles and/or headwear are proxies for racial, ethnic, and/or religious discrimination since hair textures and styles, along with cultural headwear, are phenotypic features used in categorizing race, ethnicity, and/or religious association [3-6]; and

Whereas, Title VII of the 1964 Civil Rights Act states it is unlawful for employers to discriminate against any individual based on an "... individual's race, color, religion, sex, or national origin", and section 703(a) of Title VII mentions prohibiting not only intentional discrimination, but also unintentional discrimination on the enumerated proscribed ground [7]; and

Whereas, Appearance guidelines, in the form of "race-neutral" grooming policies, used as part of medical professionalism standards tend to be euro-centric and penalize those with non-euro-centric phenotypical features and/or culture [8,9]; and

Whereas, In 2019, the State of California and New York City have passed laws to address hair discrimination within the workplace through the CROWN Act (SB 188) and the NYC Commission on Human Rights Legal Enforcement Guidance on Race Discrimination on the Basis of Hair [1,3]; and

Whereas, United States Armed Forces have repealed several bans on natural hair and cultural headwear in the workplace (Army Regulation 670-1, Section 3-2) [10]; and

Whereas, Qualitative analysis of minority resident physicians has revealed the additional challenges to embracing their racial identities in a professional setting results in less job satisfaction and more susceptibility to burnout [11]; and

Whereas, Studies show "a positive association between physician-patient racial/ethnic concordance and patients' receiving preventive care, being satisfied with their care overall..." [12]; and

Whereas, The AMA has policies (H-295.955, H-310.919, H-310.923, D-255.982,D-350.984) focused on combating racial, ethnic, and religious discrimination in medicine, but fails to include discrimination against natural hair and cultural headwear as a form of racial, ethnic, and religious discrimination; therefore be it

RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace (New HOD Policy).

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to build upon recently adopted AMA policy on racism in medicine and promotion of health equity, both of which are major priorities.

Natural hair and cultural headwear can be a proxy for racial discrimination and therefore should be protected from discrimination tactics. It has been demonstrated through the establishment of policies and laws in California, New York City, and (most recently) Cincinnati that current discrimination policies do not adequately address this specific form of discrimination. This is an incredibly common issue experienced by many of our peers in the medical community, particularly minority women. This creates an unjust educational and professional environment, as repeat chemical or heat hair treatments are costly, time-consuming, and incredibly damaging to hair and skin. This practice impedes the collective advancement of minority women in medicine and healthcare. This timely resolution would address a critical gap in existing AMA policy. By the AMA stating explicitly that natural hair and cultural headwear is professional and accepted in the medical field, it will change the culture and attitude around this topic.

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RELEVANT AMA POLICY

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)

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)

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions,

with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.
CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.
A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.
Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. (BOT Rep. ZZ, I-90,Reaffirmed by CME Rep. 9, A-98,Reaffirmed: CME Rep. 2, I-99,Modified: BOT Rep. 11, A-07,Reaffirmed: CME Rep. 9, A-13)

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. (Res. 307, A-09, Appended: Res. 955, I-17)

Eliminating Religious Discrimination from Residency Programs H-310.923
Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. (CME Rep. 10, A-06, Reaffirmed: CME Rep. 01, A-16)

Discrimination Against Physicians by Patients D-65.991
Our AMA will study: (1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and other health care systems' policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests. (Res. 018, A-18)

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign. (BOT Action in response to referred for decision: Res. 602, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(JUN-21)

Introduced by: Medical Student Section

Subject: Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, Many healthcare disparities that exist today can be attributed to exploitative structural policies targeting minorities, especially the Black community,[1–4] including disproportionate rates of incarceration,[5–7] residential segregation,[8] and unfair labor and employment policies; and

Whereas, Toxic stresses of racism[9], incarceration, community violence, and low socioeconomic status are shown to increase the likelihood of social/emotional/cognitive impairment, high-risk behavior[10], disease, and early death in minority children[11,12]; and

Whereas, The racial wealth gap in the United States has increased dramatically, as households with black children hold just one cent for every dollar held by households with non-Hispanic white children as of 2016[13,14]; and

Whereas, Income has been shown to be positively correlated with life expectancy, increased access to care, and improved health outcomes[15,16]; and

Whereas, Effects of Jim Crow era policies throughout time have severely hindered access to education and job opportunities,[17,18] which are correlated with positive health outcomes,[19,20] for the African American community; and

Whereas, The United States has never created a commission to formally study the health, economic or social impacts of slavery and the Jim Crow era on African Americans and the resolution of those injustices through the context of reparations[14,21]; and

Whereas, Reparations, encompassing a broad variety of public aid including but not limited to direct compensation, special education and job training, and community support for descendants of slaves, have been discussed as a means to support the marginalized Black community and end multi-generational poverty and its associated racial inequities[21]; and

Whereas, In 2015, Chicago became the first city in the United States to propose reparations for victims of police torture and brutality, in a measure including $5.5 million in direct compensation, free college education to survivors, a formal apology from the city, and education on police torture in public schools[22]; and

Whereas, Reparations are designed to promote intergenerational wealth amongst affected communities, which in turn will increase the health outcomes of these communities[14,23], and

Whereas, Legislators have unsuccessfully introduced House Resolution 40: "Commission to Study Reparation Proposals for African Americans Act," which asked for a study of reparations, into Congress every year since 1989[21]; and

Whereas, Individual cities and states including in California, Illinois, and North Carolina among others, are now beginning to adopt policies acknowledging a need for reparations to address racial disparities resulting in adverse health outcomes[23–25]; and

Whereas, Countries such as South Africa, which developed a Truth and Reconciliation Commission to address its history of apartheid, and France, which approved over $60 million in 2014 to be allocated to Holocaust survivors and their descendants, have implemented reparations successfully in the past[26,27]; and

Whereas, The United Nations and many of its member nations have created commissions repeatedly calling for reparations in the United States and for lawmakers to pass HR 40 or similar legislation[28-30]; and

Whereas, Reparations may serve as an avenue to alleviate some of the health, educational, and economic disparities faced by the US Black population[14,30,31]; and

Whereas, The black community is severely underrepresented in medicine, due to many societal barriers for success and the closure of all but two predominantly black medical schools after the 1910 publication of the Flexner Report[31]; and

Whereas, The AMA historically refused to establish a policy of nondiscrimination or take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships[32,33]; and

Whereas, AMA President-Emeritus Dr. Ronald Davis issued an apology on behalf of the AMA for its past wrongs and pushed the AMA towards continually addressing health disparities alongside all public health and health care stakeholders[33]; therefore be it

RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systemic racism and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the potential adoption of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our AMA made health equity and addressing racism in medicine some of its top priorities over the past year. This resolution builds upon this body of policy by asking our AMA to support the study of reparations as a means to reduce racial inequalities.
The historical exclusion of African American physicians into the AMA led to the Creation of the National Medical Association in 1895, and subsequently the Student National Medical Association in 1964. Their creation paved the way for African-American physicians and medical students to formally enter the realm of organized medicine, given that they were otherwise barred from joining previously established organizations such as the AMA. The NMA and SNMA allowed for organized support of addressing the needs of the underserved and to developing culturally competent and socially conscious physicians. Given the long historical context of this resolution, supported by the July 10th 2008 AMA apology that states in part "past history of racial inequality toward African-American physicians, and shares its current efforts to increase the ranks of minority physicians and their participation in the AMA" - The timing of this resolution is sound. We have a duty to study how reparations within the field of medicine would impact our Black patients and how we as an organization might participate in that reparative process to reduce racial health inequity.

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RELEVANT AMA POLICY

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

AMA Initiatives Regarding Minorities H-350.971

The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority

membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports: (1) A greater emphasis on **minority** access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of **Minority** Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. **minority** Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and **Minority** Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities. (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA

supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(JUN-21)

Introduced by: Medical Student Section
GLMA: Health Professionals Advancing LGBTQ Equality

Subject: Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas**,** Gender affirmation refers to the process of recognizing one's gender identity through social, psychological, and legal methods and may include medical interventions such as pubertal suppression, hormone therapy, and surgery[1]; and

Whereas**,** Gender-affirming healthcare refers to care that is sensitive, responsive, and affirming to transgender patients' gender identities and/or expressions[1]; and

Whereas**,** Transgender and gender-diverse (TGD) youth are at greatly increased mental health risks: for example, more than 50% of female-to-male transgender adolescents reported an attempted suicide, compared to 14.1% among all adolescents[2]; and

Whereas**,** TGD youth given gender-affirming treatment had lower lifetime odds of suicidal ideation as compared to those who desired but did not receive such treatment, decreasing rates of mental illness to those comparable to cisgender youth[3-5]; and

Whereas**,** Even though it is currently legal for physicians to provide gender-affirming care for TGD youth and adults, these groups already face significant barriers to receiving this care[6-7]; and

Whereas, The World Professional Association for Transgender Health (WPATH) and Endocrine Society suggest beginning medical pubertal suppression at Tanner Stage 2, which may even occur before the age of 10, and state that refusing timely gender-affirming care might prolong gender dysphoria[8-9]; and

Whereas, In 2020, at least eight state legislatures, including Missouri, Florida, Illinois, Oklahoma, Colorado, South Carolina, Kentucky, and South Dakota, have introduced legislation that would criminally punish physicians who follow evidence-based practices for treating adolescents with gender dysphoria[10]; and

Whereas, AMA policy H-65.965, Support of Human Rights and Freedom**,** opposes any discrimination based on an individual's sex, sexual orientation or gender identity[11]; and

Whereas, In May 2019, six leading medical organizations - the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association - issued a joint statement detailing opposition to "efforts in

state legislatures across the United States that inappropriately interfere with the patient-physician relationship, unnecessarily regulate the evidence-based practice of medicine and, in some cases, even criminalize physicians who deliver safe, legal, and necessary medical care"[12]; and

Whereas, Our AMA has spoken out on numerous occasions in opposition to state legislatures attempting to undermine the patient-physician relationship either through criminalizing healthcare decision-making or through censoring the content of physicians' counseling on topics like firearm safety or family planning options; and

Whereas, Our AMA has previously determined it prudent to specifically oppose the criminalization of medical care to populations that have been politicized in state legislatures, such as policy H-440.876, which supports the right of physicians to provide medical care to undocumented immigrant patients without fear of retribution; and

Whereas, Our AMA policy D-160.999 "Opposition to Criminalizing Healthcare Decisions" seeks to educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making", and the timely introduction of this resolution in the House of Delegates (HOD) further serves this purpose; therefore be it

RESOLVED, That our American Medical Association amend policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," by addition and deletion to read as follows:

> Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
> Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The AMA has long advocated for our LGBTQ+ patients and colleagues. This resolution seeks to amend policy H-185.927 and direct the AMA to active oppose efforts blocking the delivery of safe, gender-arming care by physicians. While we recognize the fantastic advocacy that AMA has already carried out to defend physician provision of gender-affirming care, this language empowers us to engage in state-specific advocacy driven by state medical associations, who may not have the existing resources or background to adequately advocate against these new bills. 2021 is unlikely to be the endpoint for these attacks, and this language demonstrates AMA's commitment to LGBTQ health equity in no uncertain terms.

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner

violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmed, A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
BOT Rep. 33, A-18

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would **criminalize** or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.
2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
Res. 402, A-12

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual’s birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive

and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.
Res. 010, A-17

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

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Res. 122, A-08; Modified: Res. 05, A-16

Government Interference in Patient Counseling H-373.995
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.
Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.
Res. 05, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(JUN-21)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, Correctional facilities, which include prisons and jails, are facilities that house people who have been accused and/or convicted of a crime[1]; and

Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees, people awaiting trial or sentence, or young offenders for short periods of time[2]; and

Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual confined to a cell for 22 to 24 hours per day, routinely used as a punishment for disciplinary violations in correctional facilities and detention centers[3]; and

Whereas, Solitary confinement is used as punishment for minor nonviolent infractions, such as not standing up for headcount or not returning a food tray[3,4]; and

Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means of reprisal for reporting unsafe and unsanitary conditions[5,6]; and

Whereas, Solitary confinement is distinguished from medical isolation and quarantine because solitary confinement is used punitively while medical isolation is used to reduce the spread of infectious disease[7]; and

Whereas, Solitary confinement consists of extended lengths of social separation, sensory deprivation, and the revocation of prison privileges, while medical isolation is a temporary measure overseen by medical professionals who treat prisoners with compassion and provide prisoners resources to aid their recovery[7]; and

Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around 60,000 people, currently reside in some form of solitary confinement[8]; and

Whereas, A year in solitary confinement costs three times as much per prisoner, or an average of $75,000 per prisoner per year[9]; and

Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs[10]; and

Whereas, Chronic social isolation stress, as perpetuated by solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes[11-13]; and

Whereas, There is a strong association between solitary confinement and self harm, for instance, one *JAMA* study found persons that held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions[4,13,14]; and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders[14]; and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality than those who do not[15]; and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses[16]; and

Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners' need for psychiatric services[12,13]; and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement[17]; and

Whereas, Spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release and other studies found a 10-25% increased overall risk of recidivism[14,18-20]; and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety[19]; and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates[20]; and

Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement[8]; and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women[21]; and

Whereas, The United Nations and The International Convention on the Rights of the Child prohibit the solitary confinement of anyone under the age of 18[22,23]; and

Whereas, In 2015 the United Nations General Assembly adopted "The Standard Minimum Rules for the Treatment of Prisoners," also known as the "Mandela Rules," which condemn the use of solitary confinement for prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures[23]; and

Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than 15 days, because it is "cruel, inhuman or degrading treatment or punishment"[23]; and

Whereas, The Mandela Rules further state that "solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review"[23]; and

Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical and psychological health issues, and should be considered cruel and unusual punishment and a human rights violation[24]; and

Whereas, At least some United States correctional facilities have managed to reform and reduce their use of solitary confinement in order to better respect the dignity and human rights of inmates while still maintaining the safety of correctional officers and inmates in jails and prisons[18]; and

Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85% without any other interventions and have seen a concurrent drop in the rate of prisoner on staff violence[18]; and

Whereas, In Mississippi, when correctional facilities reduced their solitary confinement population, violent incidents also dropped by nearly 70%[19]; and

Whereas, A 2015 study found that placing male inmates who were violent in solitary confinement did not effectively deter or alter the probability, timing, or development of future misconduct or violence[25]; and

Whereas, Some correctional facilities have created special units to protect vulnerable groups together with similar access to privileges and programs available to the general population without using solitary confinement as a means of protection[18]; and

Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New York City[26]; and

Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it

RESOLVED, That our American Medical Association policy H-430.983 be amended by addition and deletion to read as follows:

~~Reducing~~ Opposing the Use of Restrictive Housing in Prisoners ~~with Mental Illness~~ H-430.983

Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~,~~ ~~with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for a short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities. ~~and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections for marginalized and underserved populations, including the incarcerated. This resolution denounces the use of solitary confinement, which evidence has shown to threaten the physical and mental health of incarcerated and detained persons. This resolution explains that humane alternatives are available to ensure safety and prevent violence. Our delegation has worked to solicit review from advocacy and staff to ensure the issue is timely, addresses a gap in policy, and without substantial concerns on feasibility or actionability.

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.
Res. 412, A-18.

Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16.

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.

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.

Human Rights and Health Professionals H-65.981
The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.
Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15.

Human Rights H-65.997
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.
BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14.

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner’s genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.
BOT Rep. 24, A-18.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(JUN-21)

Introduced by: Medical Student Section

Subject: Improving the Health and Safety of Sex Workers

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, Sex work entails the provision of sexual services for money or goods, while sex trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act[34,35]; and

Whereas, Survival sex is the exchange of sexual activity for basic necessities such as shelter, food, or money; survival sex is considered a subset of "sex work" since it does not involve the force, fraud, or explicit coercion defined in sex trafficking; and

Whereas, Consent is defined by the federal government as a freely given agreement to the conduct at issue by a competent person, and consent is not constituted by lack of verbal or physical resistance; and

Whereas, Coercive sex—in the setting of economic, substance-related, or social vulnerability—often problematically falls under the term "consensual" sex work; thus, consent in the realm of sex work falls on a spectrum, rather than a binary definition; and

Whereas, Globally, the three major policy approaches to sex trade regulation are criminalization, full and partial decriminalization, and legalization; the US primarily utilizes criminalization; and

Whereas, Criminalization of sex work is associated with higher prevalence of unsafe practices, such as not using condoms, higher rates of STIs, lower likelihood of seeking healthcare for illness or injury related to sex work, and greater likelihood of violence and rape of the individuals selling sex;[13-18,20,23]; and

Whereas, In a study on the mental health of legal and illegal sex workers, illegal sex workers were four times more likely to report mental health issues, possibly due to increased risks that come with illegal sex work such as assault and arrest[16]; and

Whereas, Because sex work is criminalized in the United States, many sex workers struggle to obtain health insurance, leading to the majority being uninsured and paying out of pocket for healthcare[18]; and

Whereas, A systematic review of the literature estimates that 15-20% of men in the United States have paid for sex at least once[19]; and

Whereas, In 2016, over 33,000 people, many of whom were parents, were arrested for prostitution and commercial vices in the United States, putting their children at an increased risk for depression, anxiety, antisocial behavior, drug use, and cognitive delays[21,22]; and

Whereas, The threat of potential arrest forces sex workers to move their business into sparsely-populated and poorly-patrolled areas such as rural or industrial settings, where pimps and clients can perpetrate violence with impunity[26]; and

Whereas, Criminalization of sex work is associated with higher rates of sexual harassment, rape, and violence perpetrated by police against people selling sex[2,24,25,28]; and

Whereas, Individuals who sell sex for survival are often those from among the most vulnerable communities, such as undocumented immigrants, minority ethnic populations, the economically marginalized, homeless populations and especially homeless LGBTQ populations, and transgender people; [28,] and

Whereas, In a nationwide study 12% of trans women reported earning income through sex work, with higher rates among trans women of color, and 77% of these women reported intimate partner violence, 72% reported sexual assault, and 86% reported police harassment; and

Whereas, The World Health Organization, UNFPA, UNAIDS, the Global Network of Sex Work Projects, Amnesty International, and Human Rights Watch all recommend decriminalization of consensual sex work to improve access to health care for high risk populations, with the WHO specifying that decriminalization would help reduce HIV incidence[1-3]; and

Whereas, The Equality Model, in which the selling of sex is decriminalized, while buying sex, acting as a third-party profiteer, and brothel-owning are criminalized, is the most widely-followed system of partial decriminalization and is employed in Sweden, Norway, Iceland, France, Ireland, Northern Ireland, Canada, and Israel[36]; and

Whereas, In the Equality Model, people currently selling sex are offered voluntary participation in social services, and people found to be buying sex are offered voluntary participation programs to help them stop buying sex[36]; and

Whereas, Partial decriminalization strategies such as the Equality Model are associated with a markedly lower rate of human trafficking, while full decriminalization and legalization are associated with increases in human trafficking to meet the increased demand for commercial sex, as well as increases in organized crime[36,38,39]; and

Whereas, Transition from criminalization to the decriminalization of the sale of sex in the Equality Model in Sweden was shown to lower demand and overall rates of prostitution, led to a comparatively lower number of persons trafficked compared to surrounding nations using other policy systems[40]; and

Whereas, Though partial decriminalization will not eliminate all the risks of sex work, it will empower sex workers to self-organize and collaborate with law enforcement[41]; and

Whereas, Among the various systems of prostitution policy, only the Equality Model has resulted in net decreases of human trafficking, violence against sex workers, and STI rates among the general population; therefore be it

RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it further

RESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further

RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections for marginalized and underserved populations. This resolution asserts that sex work a widely misunderstood and neglected public health crisis that demands the attention of our AMA. It demonstrates the net positive public health benefits of decriminalizing sex work including stronger family units; safer work environments; decreased illegal sex tracking; improved access to healthcare by otherwise marginalized individuals; and fewer arrests of otherwise "normal," hard working citizens simply trying to live. These results have been demonstrated in United Kingdom, Australia, Belgium, Argentina, Denmark, Israel, the Netherlands, New Zealand, Spain, Switzerland, Singapore, and even in our own US state of Nevada. Clearly, sex work, in the same vein as drug use and abortion, has counterintuitive solutions that result in a better world for us all.

Our AMA has been leading the charge with evidence based solutions to many controversial issues in the past decades, and we believe that sex work is next. We urge this resolution's consideration and look forward to seeing the AMA join the WHO, UNFPA, UNAIDS, and many first world countries in destigmatizing what has long been a mislabeled immorality and improving the lives of many marginalized individuals.

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RELEVANT AMA POLICY

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.
Res. 009, A-17

Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958
Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and "best practices". Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.
Res. 14, A-15; Modified: Res. 003, I-17

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17

Global HIV/AIDS Prevention H-20.898
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to the exchange of sex for money or goods.
Res. 439, A-08; Modified: Res. 003, I-17

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.
The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.
The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
a. An assessment tool for health care professionals
b. Online training in recognizing and responding to human trafficking in a health care context
c. Speakers and materials for in-person training
d. Links to local resources across the country
The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.
2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.
BOT Rep. 20, A-13; Appended: Res. 313, A-15

Human Trafficking / Slavery Awareness D-170.992
Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.
Res. 015, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(JUN-21)

Introduced by: Medical Student Section

Subject: LGBTQ+ Representation in Medicine

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, The Association of American Medical Colleges (AAMC) has defined underrepresented minorities (URMs) in medicine as "racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" since 2003, with an overarching goal to advocate for population parity[1]; and

Whereas, The AAMC 2016 Report on Diversity in Medical Education noted that considering diversity as referring solely to race and ethnicity is too narrow and that broadening the definition of diversity would help to encompass sexual orientation, religion, geography, disability, age, language, and gender identity[2]; and

Whereas, The acronym LGBTQ+ is an umbrella term encompassing people who identify their sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as transgender; the last two components of the acronym can stand for queer or questioning and are meant to encompass all identities that are not heterosexual or cisgender[3]; and

Whereas, Individuals can belong to the LGBTQ+ community by virtue of their sexual orientation, gender identity, or both of these identity aspects[3-5]; and

Whereas, The National Institutes of Health (NIH) formally designated sexual and gender minorities (SGMs) as a health disparity population for NIH research due to mounting evidence that SGM populations have less access to healthcare and higher burdens of diseases such as depression, cancer, and HIV/AIDS[6]; and

Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of heterosexual healthcare providers reported moderate to strong implicit preference for heterosexual patients over homosexual patients, while gay and lesbian providers showed more implicit preference in favor of homosexual patients[7]; and

Whereas, In 2015, the American College of Physicians emphasized the need for “programs that would help recruit LGBT[Q+] persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians”[8]; and

Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBTQ+ people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth have experienced social ostracism because of their LGBTQ+ identity[9]; and

Whereas, Data on LGBTQ+ individuals in medicine are limited due to their self-reported nature and fear of disclosure, with the AAMC's 2018 *All Schools Summary Reports* including a caveat in the methodology that demographic data may not be generalizable[10-12]; and

Whereas, The AAMC's *Reports on Diversity and Inclusion* assert that "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine"[13]; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

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

Date received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Evidenced-based advocacy and support for our LGBTQ+ colleagues have been cornerstones in the AMA's operations and initiatives. This resolution highlights the paucity and lack of comprehensive, repeated data representing LGBTQ+ demographic data both in the general population and in medicine. It further asserts that our AMA should advocate for initiatives that intentionally recruit and reaffirm our LGBTQ+ colleagues from the start of their training in medicine. Our delegation therefore urges the consideration of this resolution by the HOD for proper discussion and review of all stakeholders within our organization.

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RELEVANT AMA POLICY:

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322 – Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. Res. 313, A-09 Modified: CME Rep. 6, A-11

Strategies for Enhancing Diversity in the Physician Workforce H-200.951 - Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06
Reaffirmed: CME Rep. 7, A- 08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16

Medical Staff Development Plans H-225.961 – All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria

related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of .patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. 2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association. BOT Rep. 14, A-98)

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878 – Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(JUN-21)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, Race is a self-identified social construct that results in differential treatment of groups that leads to social inequity on people's health[1,2]; and

Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-identification of their origin or descent, "roots," heritage, or place where the individual or their parents or ancestors were born[3]; and

Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924); and

Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and Chicano/a/x" have been used interchangeably with race in case report[4-7]; and

Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of origin and cultural heritage, constructs which can change over time[8,9]; and

Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based consensus is necessary for optimal use of self-identified race as well as geographical ancestry[10]; and

Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can contribute to the inequitable treatment of patients as it relates to evidence-based medicine[11]; and

Whereas, A current review examining ten studies and over 1.5 million participants demonstrated an association between ethnic minorities including Black, Hispanic, South Asian, Southeast Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency department[12]; and

Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in 2015, there was substantial variation between states in administrative data misclassification of self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native beneficiaries[13]; and

Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the 62 studies provided complete descriptions of their study populations[14]; and

Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to be inconsistent with current understanding of race and ethnicity[15]; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results[16]; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in black patients[16]; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology[16-18]; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and white women[4]; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in black women[19]; and

Whereas, It was seen that the rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women was less than that of U.S.-born black women and approximated those of U.S. born white women, suggesting no significant genetic basis to race differences[4]; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care[20]; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” (H-460.924); and

Whereas, Our AMA “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias[21]; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submissions concerning the incorrect use of race and ethnicity. (New HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The current momentum with respect to the discussion of race and ethnicity necessitates a foundation on the definition, and our AMA witnessed this first hand from the incident with the JAMA podcast. Our AMA has already established policy discerning that race and ethnicity are conceptually distinct. Therefore, it is in the jurisdiction of our AMA to support scientific data that correctly aligns with the related but distinct nature of these words. The resolved clauses of this resolution are supported by H-350.974, specifically "Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons."

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RELEVANT AMA POLICY

Code of Medical Ethics 7.1.5 – Misconduct in Research
Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.
Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:
(a) Do not damage science.
(b) Resolve charges expeditiously.
(c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
(d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
(e) Maintain accurate and thorough documentation throughout the process.
(f) Maintain the highest degree of confidentiality.
(g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.
Issued: 2016

Code of Medical Ethics Opinion 8.5 – Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Racial and Ethnic Disparities in Health Care, H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Reducing Discrimination in the Practice of Medicine and Health Care Education, D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision: Res. 602, I-15

Improving the Health of Black and Minority Populations, H-350.972:
Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
CLRPD Rep. 3, I-98; Reaffirmation: A-01; Modified: CSAPH Rep. 1, A-11

Reducing Racial and Ethnic Disparities in Health Care, D-350.995:
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Strategies for Eliminating Minority Health Care Disparities, D-350.996:
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(JUN-21)

Introduced by: Medical Student Section

Subject: Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, Pregnancy Counseling Centers, also referred to as Crisis Pregnancy Centers (CPC) or Pregnancy Resource Centers (PRC), are defined as non-medical entities whose aim is to dissuade women from seeking legal abortion to terminate pregnancy[1]; and

Whereas, Pregnancy Counseling Centers are intentionally advertised as comprehensive medical facilities with licensed clinical professionals despite offering only select services, providing misinformation regarding abortion and contraception, and being largely staffed by volunteers instead of licensed care providers[2,3]; and

Whereas, A majority of unintended pregnancies that occur in the United States affect vulnerable populations like minority and low-income women, which are the target population pursued by Pregnancy Counseling Centers[4]; and

Whereas, Our AMA submitted an amicus brief to the U.S. Supreme Court in the case titled *National Institute of Family and Life Advocates (NIFLA) v. Becerra* case, in support of California's 2016 Reproductive Freedom, Accountability, Comprehensive Care and Transparency (FACT) Act on the basis of "medical ethics and a patient's right to informed consent"; and

Whereas, California's FACT Act would have required all licensed medical facilities to publicly post information about affordable abortion and contraception services offered on their premises and required all unlicensed CPCs to disclose that they were not licensed medical clinics[5-7]; and

Whereas, The public health repercussions that these entities pose by influencing women's reproductive health decisions is well established by putting women at greater risk when they are interrupted from seeking abortions in a timely manner, therefore subjecting them to the increased risk associated with late term abortions or unsafe abortions[8]; and

Whereas, Pregnancy Counseling Centers perpetuate decreased prenatal care, substance abuse, preterm births, and increased incidence of negative physical and mental outcomes of babies that are born to women with unintended pregnancies[8]; and

Whereas, Our AMA recognizes the unethical practices utilized by Pregnancy Counseling Centers in the Journal of Medical Ethics, such as providing misleading and false information that falls outside of medical standards[9]; and

Whereas, These practices can cause women to miss abortion law cutoffs, receive dangerous late-stage abortions, and obstruct general access to abortion, all of which violate the ethical standards of beneficence, respect for autonomy, nonmaleficence, and justice[9]; and

Whereas, Pregnancy Counseling Centers often use federal funds from programs like Temporary Assistance for Needy Families (TANF), Title V abstinence education funding programs and Title X family planning funding programs to fund their clinic's services despite only offering a limited, and often incomplete, number of services[10, 11]; and

Whereas, Pregnancy Counseling Centers can be funded by anti-choice organizations despite not disclosing this connection, such as profits made by "Choose Life" license plates which fund Pregnancy Counseling Centers in 32 states[12]; and

Whereas, A report from the National Abortion Rights Action League (NARAL) estimates that as of 2015, $60 million in federal abstinence and marriage promotion funds have gone to Pregnancy Counseling Centers, at least 23 states have laws supporting Pregnancy Counseling Centers, 11 states fund Pregnancy Counseling Centers directly, and 20 states refer women to Pregnancy Counseling Centers [13, 14]; and

Whereas, A survey of 254 websites that identify individual Pregnancy Counseling Centers revealed only 85 contained information on male condoms or sexually transmitted infections (STIs), and of these 85, 63.5% discouraged condom use by providing negative facts about condoms, 44.7% stated marriage is protective against STIs, and 91.8% showed pictures or videos of youth on their homepage to target younger populations[15]; and

Whereas, Pregnancy Counseling Centers strategically place ads aimed at pregnant women on search engine results, billboards, and buses near abortion clinics with abortion-related terms while hiding their agenda to dissuade women from seeking legal abortions[16]; and

Whereas, Within Pregnancy Counseling Centers staff often use manipulative and deceitful tactics to dissuade women from seeking legal abortion such as wearing white coats although they hold no medical training, failing to disclose they are not a medical facility, expressing judgement to clients about their decisions to pursue abortion or contraception, offering ultrasound services for purpose of using fetal images to dissuade women from abortion, and providing false information on the links between abortion and adverse mental health sequelae, breast cancer, and future infertility[16,17]; and

Whereas, Pregnancy Counseling Centers do not charge for services and are often not licensed medical practices, therefore they are not held to the same state consumer protection statutes and consumer protection regulations that medical practices must abide by[9]; therefore be it

RESOLVED, That our American Medical Association amend policy H-420.954, "Truth and Transparency in Pregnancy Counseling Centers," by insertion and deletion to read as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by Pregnancy Counseling Centers:

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have;

2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy;

3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;

4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We feel that this resolution addresses important gaps in AMA policy surrounding crisis pregnancy centers, which can act as a public health threat to pregnant individuals nationwide by disseminating misleading medical information and violating reproductive rights. These centers endanger the health of pregnant women nationwide, who have a right to know the political and religious associations of the institutions from which they are receiving counseling services.

There are numerous policies set significant precedent such as, H-5.993 which affirms that early termination of pregnancy is a medical matter between the patient and physician thus there should be no external factors interfering. Our AMA supports the disclosure of information regarding services provided from any entity offering crisis pregnancy services. Further, it advocates that entities providing medical or health services abide by licensing requirements. However, given the current state of many pregnancy counseling centers and their deceitful tactics, a stronger rewording of current AMA policy is justifiable. Current AMA policy does not require crisis pregnancy centers to disclose their financial, political, or religious associations, leaving a gap for dubious practices to flourish. Further, these practices have been found to dissuade or sometimes coerce women seeking abortions by taking the image of a doctor (white coat) to steer a woman's choice away from abortion on a non-medical basis. The trust by our patients is us as physicians of the upmost importance and our image is part of this trust.

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RELEVANT AMA POLICY

Truth and Transparency in Pregnancy Counseling Centers H-420.954
1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further
2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.
Res. 7, I-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(JUN-21)

Introduced by: Medical Student Section

Subject: Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, The World Health Organization has unequivocally defined infertility as a disease state and cause of disability[1]; and

Whereas, Gender-affirming hormone therapy (GAHT) includes testosterone therapy for transgender men, which can suppress ovulation, and estrogen therapy for transgender women, which can lead to impaired spermatogenesis and testicular atrophy[2,3]; and

Whereas, Gender-affirming surgery (GAS) for transwomen can include hysterectomy and oophorectomy, which results in permanent sterility[2,3]; and

Whereas, The 2015 U.S. Transgender Survey of almost 28,000 people revealed that 49% of respondents had received GAHT and 25% had undergone some form of GAS[4]; and

Whereas, The World Professional Association for Transgender Health (WPATH), the Endocrine Society, and the American Society for Reproductive Medicine (ASRM) all recommend that transgender individuals receive counseling regarding potential loss of fertility and future reproductive options before initiating GAHT or undergoing GAS[5–7]; and

Whereas, As outlined in a recent AMA/GLMA issue brief, Section 1557 of the Affordable Care Act created protections barring insurance discrimination based on sexual orientation and gender identity, although the current Administration has declined to defend this regulation and has been deferential to states[8–10]; and

Whereas, Employers and states that have implemented coverage of transition-related services have demonstrated minimal or no costs with vast immaterial/societal benefits[10,11]; and

Whereas, Despite clear expert recommendations, anti-discrimination laws, and evidence of economic benefit, it is still difficult for transgender patients to obtain insurance coverage for gender-affirming care, fertility counseling, and gamete preservation[3,4,12]; and

Whereas, As of 2020, 17 states have infertility coverage mandates for private insurers, with specific requirements determined on a state-by-state basis[12,13]; and

Whereas, Seven states (Rhode Island, Connecticut, Delaware, Illinois, New Hampshire, New York, and Maryland) specify mandated coverage for iatrogenic infertility, but language around qualifying diagnoses is variable between states[12,13]; and

Whereas, "Iatrogenic infertility" has been defined in state legislation as impairment of fertility caused by surgery, radiation, chemotherapy, or other medically necessary treatment affecting reproductive organs or processes[12]; and

Whereas, GLMA policy and WPATH Standards of Care support that GAHT and GAS are medically necessary treatments for gender dysphoria, and our AMA supports coverage of medically necessary treatments for gender dysphoria as recommended by the patient's physician (H-185.950)[7,14]; and

Whereas, Our AMA supports the right to seek fertility preservation services for members of the transgender and non-binary community seeking gender-affirming hormone therapy or surgery, but does not currently address insurance coverage for these services (H-65.956); and

Whereas, Our AMA will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility is "caused directly or indirectly by necessary medical treatments as determined by a licensed physician" (H-185.990); and

Whereas, As legislation around coverage of fertility preservation continues to evolve, it is imperative that equitable insurance coverage for transgender patients is ensured; therefore be it

RESOLVED, That our American Medical Association amend policy H-185.990 by addition as follows:

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-185.950 by addition to read as follows:

Removing Financial Barriers to Care for Transgender Patients H-185.950

Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient's physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Gender-affirming therapy, including hormone therapy and surgery, is important to improving the mental health of patients experiencing gender dysphoria. It is therefore a necessary medical treatment and any resulting complications should be considered iatrogenic. Our AMA supports payment for iatrogenic infertility. However, patients who undergo gender affirming therapy and have the complication of iatrogenic infertility are often denied coverage for fertility therapy. Our delegation believes this resolution is a critical step to correcting this problem.

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RELEVANT AMA POLICY

Right for Gamete Preservation Therapies H-65.956

It is the policy of the AMA that (1): Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies; and (2) Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.
Res. 005, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all

payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Res. 150, A-88 Reaffirmed: Sunset Report, I-98Reaffirmed: CMS Rep. 4, A-08Appended: Res. 114, A-13Modified: Res. 809, I-14

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.
Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.
Res. 122 A-08; Modified: Res. 05, A-16

Infertility Benefits for Veterans H-510.984
The AMA (1) Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; (2) Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; (3) Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; (4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (5) Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
CMS Rep. 01, I-16; Appended: Res. 513, A-19

Storage & Use of Human Embryos- Ethics 4.2.5
Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes. While embryos are usually frozen with the expectation that they will be used for reproductive purposes by the prospective parent(s) for whom they were created, frozen embryos may also offer hope to other prospective parent(s) who would otherwise not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all of these possible scenarios, ethical concerns arise regarding who has authority to make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parent(s) and any individual(s) who may provide gametes. At stake are individuals' interests in procreating. When gametes are provided by the prospective rearing parent(s) or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when, and under what circumstances stored embryos may be:
(a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor.

(b) Made available to other patients for purposes of reproduction.
(c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryo(s) used for research will not subsequently be used for reproduction.
(d) Allowed to thaw and deteriorate.
(e) Otherwise disposed of.
Under no circumstances should physicians participate in the sale of stored embryos.
AMA Principles of Medical Ethics: I, III, IV, V
Issued: 2016

Assisted Reproductive Technology- Ethics 4.2.1
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice. “Assisted reproductive technology” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants. Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:
(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.
AMA Principles of Medical Ethics: I, V, VII
Issued: 2016

Reference Committee A

CMS Report(s)

02* Continuity of Care for Patients Discharged from Hospital Settings
07* Addressing Equity in Telehealth
08* Licensure and Telehealth

Resolution(s)

101 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits
102 Bundling Physician Fees with Hospital Fees
103 COBRA for College Students
104 Medicaid Tax Benefits
105 Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums
106 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
107* Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
108* Implant Associated Anaplastic Large Cell Lymphoma
109* Support for Universal Internet Access
110* Healthcare Marketplace Plan Selection
111* Towards Prevention of Hearing-Loss Associated Cognitive Impairment
112* Fertility Preservation Benefits for Active-Duty Military Personnel
113* Support for Universal Internet Access
114* Reimbursement of School-Based Health Centers
115* Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration
116* Caps on Insulin Co-Payments for Patients with Insurance
117* Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System

** Contained in the Handbook Addendum*

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)
Continuity of Care for Patients Discharged from Hospital Settings
(Resolution 212-A-19, Second Resolve)
(Reference Committee A)

EXECUTIVE SUMMARY

Medications are frequently prescribed or changed during hospital discharge, and although medication reconciliation is used by hospitals to boost adherence after discharge, barriers to filling or refilling hospital discharge medications remain. Some discharge prescriptions go unfilled due to mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record or other easily accessible tool. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to adverse tiering or prior authorization.

The Council researched numerous strategies employed by hospitals to ensure continuity of care after hospital discharge, as well as health information technology solutions such as real-time pharmacy benefit (RTPB) tools. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part, because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that the American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. Additional report recommendations support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications and call for AMA advocacy with the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services on RTPB technology.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-JUN-21

Subject: Continuity of Care for Patients Discharged from Hospital Settings (Resolution 212-A-19, Second Resolve)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

At the 2019 Annual Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 212, which was introduced by the New York Delegation and directed our American Medical Association (AMA) to advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management (PBM) companies, health insurance companies, and other payers after hospital discharge. The referred second resolve clause was crafted by the reference committee and was assigned by the Board of Trustees to the Council on Medical Service for a report back.

This report discusses strategies to ensure continuity of care and safe transitions after hospital discharge; highlights real-time pharmacy benefit (RTPB) tools intended to generate cost and coverage data at the point of care; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

The intent of the reference committee's second resolve clause of Resolution 212-A-19 is to ensure continuity of care for patients transitioning from a hospital to an outpatient setting by ensuring coverage of hospital prescribed medications that are to be continued after discharge. Adherence to medications has long been recognized to be a key component of effective medical treatment and is associated with decreases in morbidity, mortality, and hospitalizations. As discussed in Council on Medical Service Report 7-I-16, Hospital Discharge Communications, patients often experience medication-related problems during the period following hospital discharge, and more than a third of post-discharge follow-up testing is never completed.

Medications are frequently prescribed or changed during care transitions, including hospital admissions and discharges, which can be confusing for patients and put them at risk of nonadherence. Medication reconciliation—the process of reviewing and resolving discrepancies between medications a patient is using and new medications that have been ordered for the patient—is employed by hospitals during the discharge process to boost adherence to prescribed regimens and prevent adverse health outcomes. Medication reconciliation is built into the National Patient Safety Goals developed by The Joint Commission,[1] which recognizes that organizations face challenges with medication reconciliation and that its effectiveness will increase as more advanced health information technology (IT) systems are adopted.[2]

Importantly, barriers to filling or refilling hospital discharge medications remain even when medications have been effectively reconciled. Some discharge prescriptions go unfilled due to

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mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record (EHR) or other easily accessible tool. Accordingly, access to outpatient drug formularies is vital to medication management and continuity of care during patient hospitalizations and the period after discharge.

Formulary systems can be complicated and confusing for both patients and physicians. First, hospital inpatient formulary systems have traditionally been distinct from health plan outpatient formularies, which differ among themselves and are frequently adjusted (even during the benefit year). Hospitals that have merged with or grown into larger health systems, including those that have integrated with payers, may have multiple formularies in place, each of which is continuously evaluated against lists of available medications and prescribing guidelines.[3] Hospital formulary systems are managed by a pharmacy and therapeutics committee (P&T committee), which oversees medication management and use at the hospital. A P&T committee usually reports to the medical staff, which should have final approval over the hospital's medication-use policy.[4] Because hospitals/health systems are unable to procure, stock and administer all available medications, most hospital formularies make one or two medications available for each therapeutic class. A hospital formulary may also restrict the prescribing of some medications to certain specialties, although medications not available on the formulary can generally be requested.[5]

Upon admission to a hospital, hospitals may substitute a patient's home (outpatient) medication through approved therapeutic interchange if that medication is not part of the hospital's formulary. Ideally, at the time of discharge, patients should be reconciled back to their home medications to ensure continued adherence. Hospital physicians may also prescribe new medications intended for use after discharge, and those prescriptions may be based on the hospital formulary. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to restrictions such as adverse tiering or prior authorization (PA). Accordingly, patients may be discharged with prescriptions that will not be adequately covered or paid for by their pharmacy benefits plan.

Strategies to ensure continuity of care after hospital discharge

Strategies to ensure continuity of care after hospital discharge are numerous and varied and include pharmacist interventions to address medication and/or insurance issues, as well as discharge checklists that require confirmation of coverage of prescribed discharge medications. Examples of care transition interventions centered on discharge include the SafeMed care transitions model and Project BOOST (Better Outcomes for Older Adults through Safe Transitions). SafeMed uses intensive medication reconciliation and home visits to manage high-risk/high needs patients as they transition from the hospital to outpatient setting. As part of its Steps Forward™ initiative, the AMA developed a module for implementing the SafeMed model within primary care practices. Project BOOST is the Society of Hospital Medicine's signature mentoring program for improving the care of patients as they transition home from the hospital or to other care facilities. Among other interventions, Project BOOST identifies patients at high risk of hospital readmission and follows up with them to monitor adherence after discharge.

Some hospitals have established bedside medication delivery services to help mitigate the number of hospital prescriptions that go unfilled after discharge. Also known as "meds-to-beds" or "meds-in-hand" interventions, these services are provided by hospitals in partnership with their outpatient pharmacies, which are able to access outpatient formulary information[6] and coordinate PA requirements. A study of one hospital's "meds-in-hand" process highlighted use of the hospital

outpatient pharmacy to reliably verify insurance coverage of prescribed outpatient medications, and further posited that patients may incur lower costs from receiving medications from the outpatient pharmacy rather than the inpatient pharmacy.[7] Another study found that a pediatric "meds-in-hand" project increased the proportion of patients discharged in possession of their medications and may have decreased unplanned visits to the emergency department in the 30 days after discharge.[8] In addition to bedside medication delivery services, some hospitals provide a transitional supply of medications to high-risk uninsured patients at the time of discharge and also help patients obtain medications through patient assistance programs.[9] Many hospitals routinely follow up with patients after discharge to check on medication access and adherence.

Real-time pharmacy benefit (RTPB) tools

Transparency of drug coverage and formulary information in EHRs could prove useful in preventing medication nonadherence and treatment abandonment during the post-discharge period. To ensure such transparency, accurate, real-time information needs to be available at the point of prescribing. Although the AMA has been advocating that insurers, PBMs, and EHR vendors move quickly to develop point-of-care software that provides patient coverage and cost-sharing information, problems remain. Specifically, there are concerns with the accuracy of Formulary and Benefit (F&B) files based on how often payers update their formularies and provide the F&B update files to intermediaries and EHR vendors. Notably, F&B files are static and may not represent the most current formulary data. Moreover, these files do not provide drug coverage information at a granular, patient-specific level of detail.

In contrast, real-time pharmacy benefit (RTPB) technology holds promise for improving continuity of care for patients discharged from the hospital setting. Although RTPB tools are relatively new and have not yet been widely implemented, adoption continues to improve, and prescribers should have greater access to real-time benefit and coverage restriction information at the point of care through RTPB tools in the near future. To accelerate the use of electronic RTPB tools in the Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) requires every Part D plan to support one or more real-time benefit tools capable of integrating with at least one e-prescribing system or EHR, effective January 1, 2021. While this requirement falls short of ensuring that all prescribers have access to RTPB information for every patient they encounter, it is a positive step for increasing RTPB tool adoption and improving access to benefit information. In addition, CMS will require Part D plans to offer a consumer-facing RTPB tool starting January 1, 2023, which will allow patients to obtain information about medication costs and possible lower-cost alternatives under their prescription drug benefit plan.[10]

Over the past few years, the National Council for Prescription Drug Programs (NCPDP) has been developing an electronic standard for the communication of real-time prescription drug coverage and pricing information, including therapeutic alternatives, between payers and prescribers. The AMA actively participates in the NCPDP effort to ensure that the standard will provide the prescription drug information that physicians need at the point of prescribing. Based on progress of the NCPDP work, it is expected that an RTPB standard will be recommended to CMS for an eventual federal mandate under the Part D program in late 2021. Because there are several proprietary RTPB systems on the market, the AMA supports a standardized RTPB process that allows providers to access information for all of their patients, regardless of what payer the patient is covered under or what EHR/e-prescribing system is used by the provider. The AMA also strongly advocates for alignment between the prescription drug data offered in physician-facing and consumer-facing RTPB tools, as any discrepancies in the pricing or coverage information presented to these different audiences will result in increased administrative burdens for physicians, patient dissatisfaction, and mutual confusion.

AMA ACTIVITY

The AMA engages in robust federal and state advocacy on a range of policy issues relevant to improving continuity of care and preventing treatment delays after hospital discharge. The Council has previously discussed concerns related to transparency in drug formularies, which make it exceedingly difficult for physicians to determine which treatments are preferred by a particular health plan at the point-of-care (see Council on Medical Service Report 5-A-19, The Impact of Pharmacy Benefit Managers on Patients and Physicians). For patients, lack of transparency in drug coverage information may lead to treatment delays as well as being unaware of their cost-sharing responsibilities which can affect medication adherence. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthInRx.org, in 2016. At the time this report was written, nearly 350,000 individuals had signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency. The AMA has also developed model state legislation which addresses issues related to stabilized formularies and cost transparency.

To educate the public about problems associated with PA and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a second grassroots website, FixPriorAuth.org, in 2018. This site showcases an array of stories about PA requirements delaying care, including one video about a patient who had undergone heart stenting but was unable to fill a discharge prescription for a blood thinner because of a PA hurdle. The physician was unaware that the insurer would not approve the prescription, and the patient ended up back in the hospital after suffering another heart attack.

More broadly, the AMA is very active in advocating for a reduction in both the number of physicians subjected to PA and the overall volume of PA (see Council on Medical Service Report 4-JUN-21, Accountability in Prior Authorization). In January 2017, the AMA and a coalition of state and specialty medical societies, national provider organizations and patient organizations developed and released a set of 21 Prior Authorization and Utilization Management Principles intended to ensure that patients receive timely and medically necessary care and medications and reduce administrative burdens. Four of these principles speak directly to continuity of care, and Principle #8 addresses formulary data transparency in EHRs. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association in a Consensus Statement outlining a shared commitment to industry-wide improvements to PA processes and patient-centered care. The Consensus Statement underscores that continuity of care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage change and/or a change of health plan, and also addresses making PA requirements and other formulary information electronically accessible in EHRs. Additionally, the AMA has model legislation addressing PA and works closely with many state medical associations to enact legislation.

The AMA continues to advocate with the Office of the National Coordinator for Health Information Technology (ONC) and CMS around opportunities to improve health IT and EHRs, including standards, certification and vendor requirements that will help improve interoperability, EHR performance and data usability. As stated previously, the AMA participates in the NCPDP effort to advocate for physicians' interests and supports a standardized RTPB process that ensures alignment between physician-facing and patient-facing RTPB tools.

RELEVANT AMA POLICY

The AMA has extensive policy on hospital discharge and medication reconciliation. Policy D-160.945 advocates for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety. Evidence-based principles of discharge and discharge criteria are outlined in Policy H-160.942. Policy H-160.902, established with Council Report 7-I-16, encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care. This policy also encourages hospital engagement of patients and families in the discharge process, supports implementation of medication reconciliation as part of the discharge process, and encourages patient follow-up in the early time period after discharge. Policy D-120.965 also supports medication reconciliation to improve patient safety.

The AMA also has substantial policy on drug plans and formularies. Policy D-330.910 states that the AMA will explore problems with prescription drug plans, including issues related to continuity of care, PA, and formularies, and work with CMS and other organizations to resolve them. AMA policy objectives addressing managed care cost containment involving prescription drugs are outlined in Policy H-285.965, which speaks to mechanisms to appeal formulary exclusions and urges pharmacists to contact prescribing physicians if prescriptions violate the managed care formulary so that physicians can prescribe an alternative drug that may be on the formulary. Under Policy H-285.952, the AMA will continue providing assistance to state medical associations in support of state legislative and regulatory efforts to ensure continuity of care protections for patients in an active course of treatment.

Policy H-125.979 directs the AMA to: work with PBMs, health insurers and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing; promote that, in the event that a drug is no longer on the formulary when a prescription is presented, notice of covered formulary alternatives shall be provided to the prescriber so that appropriate medication can be provided; and promote the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. Council on Medical Service Report 5-A-19 established Policy D-110.987, which supports regulation of PBMs and improved transparency of PBM operations, including disclosing formulary information such as whether certain drugs are preferred over others and patient cost-sharing responsibilities, which should be made available to patients and to prescribers at the point-of-care in EHRs. Policies D-125.997 and H-185.942 support protecting patient-physician relationships from interference by PBMs and payers. Policy H-125.979 aims to prohibit drugs from being removed from the formulary or moved to a higher cost tier during the duration of a patient's plan year.

Drug formularies, P&T committees, and therapeutic interchange are addressed in Policy H-125.991, which outlines standards that must be satisfied in order for drug formulary systems to be acceptable. This policy also insists that health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated and discourages the switching to therapeutic alternates in chronic disease patients who are stabilized on drug therapy. Finally, the AMA has numerous policies on usability and interoperability of EHRs, including Policy D-478.995 on health IT which, among other directives, supports AMA advocacy for standardization of key elements of the EHR.

DISCUSSION

Although the referred second resolve clause of amended Resolution 212-A-19 focuses on continued coverage of prescribed discharge medications, the Council believes that continuity of care for medical services is also vital to improving the health outcomes of patients transitioning out of hospitals. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that our AMA advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge.

The Council recognizes that there are multiple ways for hospitals to carry out medication reconciliation and does not wish to prescribe how this process should be accomplished. Some hospitals assign staff (usually pharmacy staff) to work through coverage issues and facilitate patient access to discharge medications. Others utilize hospital outpatient pharmacies to review coverage and PA requirements during the reconciliation process. The Council recommends supporting—but not requiring—medication reconciliation that includes confirmation that prescribed discharge medications will be covered by a patient's health plan and completion of PA requirements.

Aside from medication reconciliation, the Council identified other innovative strategies employed by hospitals to improve medication adherence after hospital discharge. "Meds-to-beds"/"meds-in-hand" services take a variety of forms and can be administered hospital-wide or for specific patient populations. However, these programs may not be achievable at all facilities, particularly those without an outpatient pharmacy on site. Safety-net hospitals are more likely to provide an initial 30-day supply of medications to uninsured patients, and the Council supports these efforts—and broadening them—while acknowledging the cost implications for hospitals. Accordingly, the Council recommends a more general policy statement supportive of strategies to address coverage barriers and facilitate patient access to prescribed discharge medications, such as bedside medication delivery services and the provision of transitional supplies of discharge medications.

The Council believes that RTPB systems hold promise for improving continuity of care during the discharge period and looks forward to the release of an RTPB standard, widespread implantation of this technology in physicians' and hospitals' EHR systems, and ongoing evaluations of and improvements to these tools to ensure that RTPB technology meets the needs of prescribers. At this time, the Council believes it is premature to require EHR vendors to incorporate RTPB for certification. Instead, the Council recommends that our AMA advocate that ONC and CMS work with physician and hospital organizations, and health IT developers, to identify RTPB implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and EHR vendors. The Council further recommends that any policies requiring health IT developers to integrate RTPB systems within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. Finally, the Council believes that it is critically important for the data offered on emerging consumer-facing RTPB tools to match the drug pricing and coverage information displayed in physicians' and hospitals' EHRs, as discrepancies will lead to confusion and dissuade both physicians and patients from using these technologies. Accordingly, the Council recommends that our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

The Council acknowledges the strength of AMA policy on problems with prescription drug plans and formulary transparency and recommends reaffirmation of Policies H-125.979 and D-330.910. Previous Council reports on hospital discharge communications and physician communication and care coordination during patient hospitalizations underscored that consistent physician-to-physician communication across care settings is integral to achieving a safe and efficient discharge process. The Council recommends reaffirmation of Policy D-160.945, which supports timely and consistent communication between physicians in inpatient and outpatient care settings.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy)

2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy)

3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy)

4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy)

5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)

6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools. (New HOD Policy)

7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work to resolve them. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between physicians in inpatient and outpatient settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)
Addressing Equity in Telehealth
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)
(Reference Committee A)

EXECUTIVE SUMMARY

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council decided to initiate a report addressing equity in telehealth, believing that additional AMA policy is needed to advocate for solutions and infrastructure that facilitate equitable telehealth access. In addition, this report specifically responds to Items (a) and (c) of the second resolve of Alternate Resolution 203 that were referred and referred for decision, respectively, at the November 2020 Special Meeting of the House of Delegates.

Existing AMA policy addressing equity in telehealth recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

The Council welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the novel coronavirus pandemic. To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-JUN-21

Subject: Addressing Equity in Telehealth
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council believes that additional AMA policy is needed that advocates for solutions and infrastructure that facilitate equitable telehealth access. Policy D-480.963, newly adopted at the November 2020 Special Meeting of the House of Delegates, states that our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and supports the use of telehealth to reduce health disparities and promote access to health care. This new policy provides an essential foundation upon which additional policy addressing equity in telehealth can be developed and is consistent with the AMA's recent adoption of a new, eighth enterprise value embracing equity, which states: "We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation." Furthermore, AMA's vision statement for health equity states: "The AMA's vision for health equity is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, everyone has the power to achieve optimal health, and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the health care system."

In addition, at the November 2020 Special Meeting of the House of Delegates, four potential additions to the second resolve of Alternate Resolution 203 were referred or referred for decision. The second resolve of Alternate Resolution 203-Nov-20, which is now Policy D-480.963[2] asked:

> That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:
>
> 1. provide equitable coverage that allows patients to access telehealth services wherever they are located; and
> 2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second resolve. Items (a) and (b) were referred. Items (c) and (d) were referred for decision.

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a) promote continuity of care by preventing payers from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
c) provide equitable payment for telehealth services that are comparable to in-person services.
d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Items (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report specifically responds to Items (a) and (c); Council on Medical Service Report 8, also being considered at this meeting, addresses Items (b) and (d).

This report provides background on barriers to and inequities in accessing telehealth; highlights programs and pathways to augment the ability of physicians to provide telehealth to historically marginalized and minoritized communities; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

The expansion of telehealth services as a result of the novel coronavirus (COVID-19) pandemic has positively impacted patients who now have the ability to utilize telecommunication technology to access their physicians without having to navigate public transportation in densely populated urban communities, take time off from work to commute to and from the appointment, or drive lengthy distances in rural areas to attend an outpatient office visit with a specialist. In addition, telehealth provides a mechanism to overcome other barriers affecting patients' ability to access in-person services, including functional impairments that make it difficult to get to a physician's office or require a family member, friend, or caregiver to accompany the patient, and the need to find care for children or grandchildren. Importantly, the increased use of telehealth provides another pathway for physicians to learn more about the social determinants of health that may influence a patient's health and access to health care, including one's living environment, economic stability and food security.

Overall, according to a recent survey, during the first six months of the COVID-19 pandemic, one-third of adults ages 18 to 64 reported having had a telehealth visit--defined in the survey as either audio-only or two-way audio-video. Adults with multiple chronic conditions as well as those in poorer health were much more likely to report using telehealth to access care than their counterparts. Black and Hispanic adults were more likely to use telehealth than White adults, and adults living in metropolitan areas were more likely to have used telehealth than adults living outside metropolitan areas. At the same time, patients reported going without a telehealth visit despite wanting one; adults in fair or poor health, those with chronic conditions, and Hispanic adults were more likely to report going without wanted telehealth care.[1] Of the Medicare fee-for-service population, more than 9 million beneficiaries received a telehealth service during the period ranging from mid-March through mid-June of 2020. More than 20 percent of Medicare beneficiaries residing in rural areas used telehealth services during that time, with 30 percent of beneficiaries in urban areas accessing telehealth services.[2]

Examining outpatient visits and telehealth use in a database of 16.7 million commercially insured and Medicare Advantage enrollees, a study showed that 30.1 percent of all visits from

March 18, 2020, to June 16, 2020, were provided via telehealth. During this period, the weekly number of telehealth visits among the population studied increased to 397,977 visits per week, up from 16,540 visits per week during the period from January 1, 2020, to March 17, 2020. However, not all of these services were distributed evenly across different population groups. Notably, the percentage of total visits provided via telehealth was smallest among those ages 65 and older. In addition, health plan enrollees residing in counties with the lowest percentages of residents with incomes below the federal poverty level, and percentages of White residents had a greater proportion of total visits delivered via telehealth from March to June 2020 when compared with counties with higher percentages of these residents. In addition, a lower percentage of care was provided by telehealth in rural counties than in urban counties.[3]

Other studies also have reported inequitable access to telehealth services during the COVID-19 pandemic, as well as potential reliance on or preference for audio-only visits over two-way audio-video visits. For example, a cohort study of patients with appointments for primary care and specialty ambulatory telehealth visits during March through May of 2020 at a large academic health system showed that older adults, patients with limited English proficiency, Medicaid beneficiaries, and Asian patients had lower rates of telemedicine utilization. The study also found that Black, Hispanic, lower-income, female and older patients had lower rates of two-way audio-video utilization.[4] In addition, a claims-based analysis of approximately 7 million commercially insured patients found that, in the early stages of the pandemic in March and April of 2020, zip codes with 80 percent or more residents of historically minoritized racial/ethnic communities had smaller reductions in the use of in-person office visits, and smaller increases in the use of telehealth, than zip codes with 80 percent or more White residents.[5] CMS has estimated that of the Medicare fee-for-service beneficiaries who accessed a telehealth service in the early months of the pandemic, 30 percent used audio-only telephone technology,[6] with other studies showing higher rates of utilization of audio-only visits among low-income patients.[7]

BARRIERS TO TELEHEALTH ACCESS FOR PATIENTS

Telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities that have been impacted disproportionately by the COVID-19 pandemic. However, far more emphasis needs to be placed on ensuring that telehealth solution functionality, content, user interface, and service access are designed in an equity-centric participatory fashion with and for historically minoritized and marginalized communities, including addressing culture, language, digital literacy ability, and broadband access. In addition to assessing how solutions are designed, it is also critical that an upstream lens is used to understand the root causes of barriers to optimal use of telehealth services within historically marginalized communities, namely systemic racism and inequitable resource allocation impacting infrastructure development and access to economic and education opportunities.

In 2019, 25 million individuals in the US did not have internet access at home, and 14 million did not have equipment capable of playing video--essential for two-way audio-video telehealth--such as a smartphone, tablet, computer or other connected device.[8] Not all home internet services are equal; speed and bandwidth issues may continue to serve as obstacles to accessing telehealth services even for patients who have internet access at home. In addition, patients who only have a smartphone and solely rely on their phone's data plan and capacity for internet access may confront data and bandwidth challenges in accessing two-way audio-video telehealth visits.

There are, notably, racial and ethnic inequities in access to the internet, with a larger percentage of Black and Hispanic individuals not having internet access at home. Individuals residing in rural

areas are less likely to have access to the internet at home than those in urban areas. Age-related disparities also exist, with older individuals being less likely to have internet access at home. Significantly, Medicare and Medicaid beneficiaries make up two-thirds of those who lack internet access at home, and the uninsured make up 15 percent.[9]

In addition, the continued use and expansion of telehealth rely on equitable design to meet the need for varying levels of patient digital literacy, and how the availability of telehealth services is communicated to patients. Individuals without access to a computer or smartphone may be left out of telehealth service offerings. Even among patients with equitable access to devices and to the internet, there remain exclusionary and suboptimal design issues requiring patients to navigate email, fill out a form online or find a website--significant barriers to participating in a two-way audio-video telehealth visit. Requiring the use of a patient portal for accessing telehealth services can serve as another barrier for patients. Furthermore, the lack of transparency and equity in the design of privacy and security policies and practices in many telehealth solutions cause hesitancy among some patients as to the safety and security of telehealth visits with their physicians.

AUGMENTING THE ABILITY OF PHYSICIANS TO PROVIDE TELEHEALTH TO HISTORICALLY MARGINALIZED AND MINORITIZED POPULATIONS

To help close the digital divide in access to telehealth services, initiatives at the state and federal levels can serve as examples of, and first steps towards, what needs to be done to address some of the upstream barriers to equity in telehealth--including ensuring affordable access to needed technology to engage in two-way audio-video telehealth and investing in broadband capacity in underserved communities. Patient access to telehealth is inextricably linked to whether and how such services are covered by their health plans, including whether they can use telehealth to access care from their regular physician. Barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only.

Federal and State Initiatives Addressing Equity in Telehealth Service Delivery and Access

Increased investments in telehealth service delivery and access are essential to ensure patients can maintain needed access to health care regardless of where they are and augment the ability of physicians to provide telehealth to populations who cannot currently access telehealth services. Federal initiatives have recently been launched to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. In addition, many states have leveraged available Medicaid authorities to provide technology and care coordination support to augment the ability of Medicaid beneficiaries to access telehealth services during the COVID-19 pandemic.

Connected Care Pilot

Under the auspices of the Federal Communications Commission (FCC), the Connected Care Pilot Program is a temporary program that will provide up to $100 million over a three-year period to defray the costs faced by selected health care providers in providing connected care services, prioritizing providing these services to low-income or veteran patients. The Connected Care Pilot will cover 85 percent of the eligible costs incurred by selected pilot programs of patient broadband internet access services, health care provider broadband data connections, other connected care information services, and certain network equipment. Provider eligibility for the Connected Care Pilot Program is limited to public and nonprofit providers, including community health and mental

health centers; local health departments; rural health clinics; skilled nursing facilities; not-for-profit hospitals; and other entities.[10]

COVID-19 Telehealth Program

The COVID-19 Telehealth Program was established by the FCC in response to the COVID-19 public health emergency to assist health care providers in providing connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. The FCC adopted the Program in a report and order released in April 2020. Through this program, the FCC will distribute the $200 million appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, providing immediate support to eligible health care providers--limited to public and nonprofit providers like the Connected Care Pilot--responding to the COVID-19 pandemic. The FCC has outlined the following examples under the auspices of the three main categories of eligible services related to the delivery of connected care that could be funded under the Program:

- Telecommunications Services and Broadband Connectivity Services: Voice services for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equipment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.[11]

Emergency Broadband Benefit Program

In February 2021, the FCC formally adopted a report and order to establish the Emergency Broadband Benefit Program, a program with $3.2 billion in federal funding aimed at providing financial assistance to qualifying households to help cover the costs of broadband and device ownership. Broadband access and device ownership are critical building blocks to enable more equitable patient access to telehealth. Under the program, eligible households can receive discounts of up to $50 per month for broadband service, up to $75 if the household is on Tribal lands. Eligible households will also be eligible for a one-time discount of up to $100 for the purchase of a computer or tablet. Households eligible for assistance under the Emergency Broadband Benefit Program include those that participate in an existing low-income or pandemic relief program offered by a broadband provider; Lifeline subscribers, including those who are Medicaid beneficiaries or receive Supplemental Nutrition Assistance Program (SNAP) benefits; households with children receiving free or reduced-price school meals; Pell grant recipients; and those who have lost jobs and experienced reductions in their income in the past year.[12]

Medicaid Appendix K Waivers

Medicaid Appendix K is a stand-alone appendix that states can use during emergencies, such as the COVID-19 pandemic, to request amendment to approved 1915(c) home and community-based waivers. During the COVID-19 pandemic, states have used Medicaid Appendix K authority to provide needed technology and care coordination support to targeted beneficiaries. For example, New Mexico was approved to provide up to $500 to select Medicaid beneficiaries who do not

currently have access to a computer, tablet or other device to purchase such a device to support their access to telehealth, including two-way audio-video as well as needed training.[13] Kansas was approved under Medicaid Appendix K authority to provide remote monitoring technology and requisite training to beneficiaries with chronic diseases.[14]

Covering Telehealth Services by Patients' Physicians

Referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting was to "promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice." Patient access to telehealth is inextricably linked to whether telehealth services provided by their physicians--the physicians with whom they have a relationship--are covered by their health plan. The AMA has been highly active on the state and federal levels to ensure that health plans allow all contracted physicians to provide care via telehealth, and that cost-sharing is not used to incent care from other providers. Prior to the COVID-19 pandemic, many health plans established a separate network for telehealth or select telehealth providers, which did not always include contracted physicians who provide in-person services. As a result of the pandemic, adoption of telehealth has increased dramatically and is more likely to be available from an individual's physician. AMA advocacy on the state and federal levels has underscored that the pre-pandemic separation of telehealth and in-person visits can no longer be justified based on low levels of adoption that no longer exist. In addition, the AMA has stressed that the perpetuation of separate networks is confusing for patients and threatens continuity of care and the patient-physician relationship.

For example, AMA model state legislation addressing this issue, the Telemedicine Reimbursement Act, states that "each carrier offering a health plan in this state shall provide coverage for the cost of health care services provided through telemedicine on the same basis and to the same extent that the carrier is responsible for coverage for the provision of the same service through in-person treatment or consultation. Coverage must not be limited only to services provided by select corporate telemedicine providers." In addition, in an April 2020 comment letter in response to a proposed rule on the Medicare Advantage program, the AMA stated that "the rapid deployment of telehealth services by physicians in response to the COVID-19 pandemic is significantly changing the practice of medicine in ways that are likely to last long after the pandemic. Many patients are now having office visits with their regular physicians via telehealth. The AMA strongly encourages MA plans to cover telehealth visits and other services, at a minimum for those on the Medicare telehealth list, with their physicians. The AMA is aware that some plans contract with telehealth providers and encourage their enrollees to use these other services instead of covering telehealth services provided by the patients' regular physicians. Patient advocates have made it very clear that what is most important to patients is for all members of the patient's health care team to be involved in, and adhere to, the patient's treatment plan. This continuity of care will not be possible if patients are directed to separately contracted telehealth providers even when the patients' regular physicians are able to provide the services via telehealth themselves."[15]

In addition, AMA advocacy has underscored that the cost-sharing for services provided via telehealth should not vary based on the telehealth provider. Reducing cost sharing for select telehealth providers who do not also provide in-person care inappropriately steers patients away from their current physicians, fragmenting the health care system and threatening patients' continuity of care. Importantly, the AMA has stressed that health insurers should ensure transparency in coverage and patient cost-sharing of services provided via telehealth, and health care professionals should effectively communicate information about the scope of telehealth visits to patients.

Ensuring Fair and Equitable Payment for Two-Way Audio-Video and Audio-Only Visits

Relevant to Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, several states enacted Executive Orders early in 2020 requiring payers to provide equivalent payment for two-way audio-video visits, and sometimes audio-only visits, as compared to in-person visits. Through the end of the COVID-19 public health emergency, CMS will continue to pay for telehealth visits equivalent to in-person office visits. In the Final Rule for the 2021 Medicare Physician Payment Schedule, CMS stated that audio-only visits, described by CPT codes 99441-99443, will not be payable after the conclusion of the COVID-19 public health emergency. CMS will allow payment, however, for brief communication technology-based services (e.g., virtual check-in), described by codes G2251 and G2252, at 2021 payment rates of $15 and $27 respectively.

During the COVID-19 public health emergency, two-way audio-video visits are reported with existing Current Procedural Terminology (CPT) codes for office visits. Prior to the COVID-19 public health emergency, payment for two-way audio-video telehealth visits was typically equivalent to an office visit provided in a facility setting (e.g., outpatient hospital clinic), where the physician is presumed to incur no direct costs (clinical staff, medical supplies and equipment). During the COVID-19 public health emergency, payment for two-way audio-video visits was paid equivalent to an office visit provided in a non-facility setting (e.g., physician's office). It is likely that the CPT Editorial Panel will receive an application to modernize the CPT codes describing audio-only services to address the CMS concerns and to align with the temporary G codes. After such an action, the AMA/Specialty Society RVS Update Committee would review the resources typically required to perform these services.

RELEVANT AMA POLICY

Newly adopted at the November 2020 Special Meeting of the House of Delegates, Policy D-480.963 states that our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-CoV-2; (2) will advocate that the federal government, including CMS and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Policy H-478.996 states that it is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology.

Relevant to referred-for-decision Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy D-480.965 states our AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. Established by Council Report 7-A-14, Policy H-480.946 outlines principles to guide

the coverage and payment of telemedicine services. Regarding payment for audio-only visits, Policy H-390.889 states that our AMA supports and advocates with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; and continues to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services.

Relevant to referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy H-480.946 states that patients seeking care delivered via telemedicine must have a choice of provider; and that telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. Policy D-155.987 advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information or other plan designs that may affect patient out-of-pocket costs.

DISCUSSION

While the AMA has foundational policy pertaining to the coverage and payment for telehealth, Policy D-490.963, adopted at the November 2020 Special Meeting, serves as an essential step forward in developing policy specific to addressing equity in telehealth. The new policy, as well as Policy H-478.980, recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit. As such, the Council recommends reaffirmation of Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

In addition, it is essential for physicians to serve as leading partners in efforts to improve the access of historically marginalized and minoritized communities to telehealth services. The Council

welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. However, eligibility of physician practices for these programs remains quite limited, and the Council sees tremendous potential in expanding eligibility for these programs so that physicians are able to help their patients engage with and access telehealth services.

To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Policy D-480.969 provided a policy foundation in this regard, advocating for telemedicine parity laws that do not limit coverage only to services provided by select corporate telemedicine providers, relevant to the emergence of companies including Amazon expanding in the telehealth space. The Council is concerned that physicians are being prevented from, or facing barriers to, providing covered services via telehealth to their patients. In addition, cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network. Such incentives could also include creating separate cost-sharing requirements or structures for in-person care and care provided via telehealth.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. The expanded use of audio-video telehealth services during the COVID-19 pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients and those in rural and other areas with limited internet access. In addition, some patients, even those who own the technology needed for two-way real-time audio-video communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Fair and equitable payments will help ensure that patients are able to receive the right care, via the most appropriate and accessible modality, at the right time.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy)

3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy)

4. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (New HOD Policy)

5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. (New HOD Policy)

6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD Policy)

7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (New HOD Policy)

8. That our AMA support expanding physician practice eligibility for programs that assist providers in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)

9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. (Reaffirm HOD Policy)

10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth. (New HOD Policy)

11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (New HOD Policy)

12. That our AMA advocate that payments should consider the resource costs required to provide all physician visits and payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)
Licensure and Telehealth
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)
Reference Committee A

EXECUTIVE SUMMARY

This report is the Council's second on licensure and telehealth in as many years and responds to elements (b) and (d) of the second Resolve of Alternate Resolution 203 that the House of Delegates referred during its November 2020 Special Meeting. Since the Council's previous report (Council Report 1-I-19, Established Patient Relationships and Telemedicine) was presented, the coverage and payment landscape for telehealth has changed considerably in response to the novel coronavirus (COVID-19) pandemic, enabling physicians to provide uninterrupted care to patients while adhering to social distancing. The surge in virtual visits across most practices and settings has been so significant that more than three-quarters of physicians reported using telehealth in 2020, up from one quarter in 2018. The Council anticipates that most physicians who increased their use of telehealth during the public health emergency will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care.

The Council acknowledges the breadth of existing American Medical Association (AMA) licensure and telehealth policy and the organization's long history of supporting solutions that make it easier for physicians to obtain licenses to practice medicine across state lines while protecting patients and preserving state oversight of the practice of medicine. The Council continues to support the Interstate Medical Licensure Compact as an important licensure solution and recommends reaffirmation of AMA policy supportive of the Compact and reduced application and licensure fees.

This report addresses a common frustration among physicians—that, outside of the temporary licensure flexibilities put in place during the public health emergency, they are prohibited by most states from using telehealth to provide longitudinal care to existing patients who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with the Federation of State Medical Boards and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met.

The Council believes the recommendations in this report will increase physician and patient satisfaction with health care, reduce physician administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-JUN-21

Subject: Licensure and Telehealth
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

At the November 2020 Special Meeting of the House of Delegates, four potential additions to the second Resolve of Alternate Resolution 203 were referred or referred for decision. The second Resolve of Alternate Resolution 203-I-20, which is now Policy D-480.963[2] asked:

> That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that (1) provide equitable coverage that allows patients to access telehealth services wherever they are located; and (2) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second Resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

> a) promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
> b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
> c) provide equitable payment for telehealth services that are comparable to in-person services.
> d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Paragraphs (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report is specifically responding to Paragraphs (b) and (d); Council on Medical Service Report 7, also being considered at this meeting, is addressing Paragraphs (a) and (c).

This report provides an overview of physician licensure and telehealth, describes exceptions to licensing laws authorized by states before and during the novel coronavirus (COVID-19) pandemic, summarizes relevant AMA policy, and makes policy recommendations. For the purposes of this report, the term "telehealth" refers to digital health solutions that connect patients and clinicians through real-time audio and video technology.

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BACKGROUND

In response to the spread of COVID-19, widespread stay-at-home orders, and federal and state policy changes instituted last spring, the use of telehealth by physicians and other health professionals expanded exponentially. Swift adoption of telehealth across most practices and settings enabled physicians to provide uninterrupted continuity of care while adhering to social distancing that protected patients and health professionals from exposure to the virus. The surge in telehealth is reflected in data from recent biennial AMA Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. Benchmark Survey data show a substantial increase in the use of telehealth between 2018 and 2020, with 79 percent of physicians reporting use of telehealth in their practice in 2020, up from 25 percent in 2018.[1] Additionally, last summer more than 75 percent of respondents to the Telehealth Impact Physician Survey said that telehealth enabled them to provide quality care for COVID-19-related care, acute care, chronic disease management, hospital or emergency department follow-up, care coordination, preventive care, and mental or behavioral health.[2] Sixty percent of physicians reported that telehealth has improved the health of their patients, while 55 percent indicated that telehealth has improved their work satisfaction.[3] Payment (73 percent) and technology challenges for patients (64 percent) were cited by a majority of physicians as barriers to maintaining telehealth after the pandemic, while 18 percent of physicians cited licensure as a barrier.[4]

The Council anticipates that many physicians who increased their use of telehealth during the pandemic will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care. The AMA continues to study telehealth use to better understand the needs of patients and physicians as well as the overall impact of telehealth on care quality and patient outcomes. At the same time, the AMA engages in robust federal and state advocacy on telehealth, weighing in on a range of policy proposals including the temporary flexibilities put in place during the public health emergency as well as proposals that will shape the practice of telehealth post-pandemic.

Interstate licensure and telehealth were addressed in Council Report 1-I-19, Established Patient Relationships and Telemedicine, which highlighted concerns raised by physicians that the nation's state-based licensure system has impeded growth in telehealth use by medical homes and other physician practices, including those wishing to provide telehealth services to their regular patients when those patients travel to another state. In adopting the Council's 2019 report, the House of Delegates reaffirmed long-standing AMA policy maintaining that physicians delivering telemedicine services must be licensed in the state where the patient receives services (Policies H-480.946 and H-480.969). Additionally, by adopting the recommendations in the report, the House established Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining; advocate for reduced application and state licensure(s) fees processed through the IMLC; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.

Council Report 1-I-19 highlighted the rationale behind state oversight of the practice of medicine and the licensure of physicians to practice within a state's borders. State authority to protect the health, safety and general welfare of its citizens was granted in 1791 under the 10th Amendment of the US Constitution, with formal licensing of physicians through state medical boards dating back to the 1800s.[5] The primary goals of state medical boards are to protect patients, ensure quality health care, and foster the professional practice of medicine. In addition to issuing licenses, state

medical boards are authorized to investigate complaints and take disciplinary action against the licenses of those who violate state law. States also license a range of other health professionals, including physician assistants and nurses, and establish scope of practice parameters within the state to safeguard the practice of medicine.

The prevailing standard for medical licensure found in the medical practice acts of each state affirms that the practice of medicine is determined to occur where the patient is located. This standard enables states to ensure that health professionals adhere to that state's laws and regulations (e.g., licensing requirements and scope of practice parameters) and to protect the public from the unprofessional and improper practice of medicine. Because the standards and scope of telehealth services should be consistent with related in-person services (consistent with Policy H-480.946), most states similarly require physicians utilizing telehealth to be licensed in all jurisdictions where patients receive care. Licensure requirements established by state medical boards may vary but, according to the Federation of State Medical Boards (FSMB), 49 state boards—as well as the medical boards of the District of Columbia, Puerto Rico, and the Virgin Islands—require physicians practicing telehealth to be licensed in the state in which the patient is located.[6]

INTERSTATE LICENSURE

Recognizing the costs and burdens associated with obtaining physician licenses to practice medicine in multiple states, the AMA has long supported making it easier to obtain licenses to practice across state lines, and addressing the cost, time and administrative burdens while preserving the ability of states to oversee the care provided to patients within their borders. Advances in telehealth, and the potential to increase access to virtual care among people in rural and underserved communities, increasingly motivated stakeholders to seek solutions that would streamline licensure processes across state lines. Ultimately, these efforts culminated in the development of the IMLC.

Interstate Medical Licensure Compact

In 2017, the IMLC became operational establishing a new expedited pathway to licensure for qualifying physicians seeking to practice in multiple states. From the beginning, the AMA strongly supported the IMLC as a means of facilitating expedited licensure while ensuring that states retain the authority to regulate the practice of medicine and protect patient welfare. The IMLC adopts the prevailing standard that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter. A physician practicing under a license facilitated by the IMLC is thus bound to comply with the statutes, rules, and regulations of each state wherein he/she chooses to practice medicine.

At the time this report was written, the IMLC was an agreement among the following 30 states, the District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.[7] Compact authorizing legislation has been introduced in Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Rhode Island and Texas, with other states expected to introduce legislation during 2021 legislative sessions.[8]

Over 17,000 licenses have been issued by IMLC,[9] and the IMLC Commission estimates that 80 percent of physicians in Compact states meet the criteria for licensure.[10] However, physicians

practicing in several heavily populated states—e.g., California, Florida, Massachusetts, New York and Texas—are unable to apply for expedited licenses through the IMLC since those states have not passed authorizing legislation to join the Compact. Physicians practicing in Compact states are similarly unable to use the IMLC to obtain expedite licenses in these non-Compact states.

Costs associated with Compact licenses/renewals remain an additional barrier to increased licensing via the IMLC, since physicians who want to apply must pay an initial $700 fee plus cover the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.[11] Licensing fees in Compact states range from $75 in Alabama and Wisconsin to $790 in Maryland, with most states charging several hundred dollars. These costs may be beyond the budgets of many physician practices—particularly small practices—that continue to face COVID-19-related financial pressures. A nationwide physician survey conducted by the AMA in July-August 2020 found that practice revenue had dropped by a third, on average, and spending on personal protective equipment (PPE) had increased 57 percent.[12] Despite an increase in telehealth use, almost 70 percent of physicians were still providing fewer total visits (in-person plus telehealth) at the time of the survey than before the pandemic.[13]

Exceptions to State Licensing Laws Pre-COVID-19

Prior to the pandemic, physicians licensed by states that had not joined the IMLC or who wanted to practice in a non-Compact state were generally required to go through that state's traditional, often lengthy, licensure application process. Allowances for circumstances under which out-of-state physicians may practice in a state without being licensed vary by state and were predominantly limited pre-pandemic to physicians consulting with in-state physicians and physicians practicing in emergencies or responding to natural disasters. Although licensing requirements across states share many commonalities, each state has its own rules and exceptions to those rules. Colorado's Medical Practice Act [§ 12-240-107(3)(b)], for example, uniquely permits physicians licensed and lawfully practicing medicine in another state to provide "occasional services" in Colorado, provided they do not have a regular practice in Colorado and maintain malpractice insurance.[14]

Some states had licensure policies specific to interstate telehealth in place before the pandemic. According to FSMB, 12 state medical boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines, while six state boards require physicians to register if they wish to practice across states.[15] Florida is an example of the latter. Despite opposition from the Florida Medical Association and other health providers, Florida enacted a law in 2019 allowing out-of-state health professionals to provide telehealth services in the state without a Florida license if they register with the state medical board.

The Uniform Emergency Volunteer Health Practitioners Act (UEVHP) allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the District of Columbia that have enacted the Act.[16] Some states have enacted universal licensure recognition laws to allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.[17]

Physicians and other health professionals employed by the US Veterans Administration, the Indian Health Service and the US Department of Defense are generally permitted by these health systems to practice—including via telehealth—outside of the state where they are licensed. States also recognize the licenses of National Disaster Medical System physician team members. The Sports Medicine Licensure Clarity Act, passed by Congress in 2018, enabled sports medicine

professionals to provide medical care to athletes and team members while traveling with an athletic team in a state in which they are not licensed. Under this law, services provided by a sports medicine professional are deemed to have occurred in the professional's primary state of licensure. The law further extends medical professional liability insurance to cover the professional with respect to medical care provided while out of state with the team.[18]

Liability concerns are integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

Licensing Waivers in Response to COVID-19

COVID-19 led to a slew of federal and state temporary waivers of telehealth coverage and payment regulations intended to expand the scale and reach of telehealth, thereby meeting the increased demand for virtual medical care. Federal and state licensure requirements were also waived, enabling health care professionals to work across state lines and provide care in areas hardest hit by the pandemic without having to seek licenses in those states. After the President and US Department of Health and Human Services Secretary declared a public health emergency in March 2020, CMS used its 1135 waiver authority to temporarily waive requirements that out-of-state physicians and other health professionals be licensed in the state where they are providing services when they are licensed in another state. Licensing requirements were waived for physicians and other health professionals participating in the Medicare, Medicaid and Children's Health Insurance Program programs and meeting the following four conditions: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state; 3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and 4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area.[19]

CMS' actions did not waive state or local licensure requirements, which remain in effect unless also waived. Accordingly, for a physician or other health professional to avail him- or herself of the CMS waiver under the conditions described above, the state would also have to have modified its licensure requirements. Many states did so by implementing temporary changes that to varying degrees permit physicians licensed in other states to provide medical services during the public health emergency. Some states issued broad reciprocity waivers permitting physicians and other health professionals possessing an active license in good standing in another state to provide care without obtaining a license, temporary or otherwise, in that state. Other states required registration with or approval by the state medical board. Some waivers were more targeted, presumably based on a state's needs, and several states established emergency temporary licensure or certification processes that out-of-state providers must go through to seek permission to practice. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to patients in that state, or by physicians in contiguous states that have existing patient relationships with state residents. At the time this report was written, a few states had already rescinded their temporary licensure waivers while Idaho's Governor, via executive order, had declared that all the state's waivers, including the change allowing out-of-state physicians to provide telehealth services to Idaho residents, be made permanent. States modifying licensure requirements for physicians in response to COVID-19, and states waiving telehealth licensure requirements, are tracked by FSMB.

The AMA has supported the need for flexibilities to effectively respond to COVID-19 but does not currently support extending the CMS licensure waiver beyond the end of the public health emergency. To protect patients, the AMA has long advocated that physicians and other health professionals providing care via telehealth must be licensed or otherwise authorized to practice in the state where the patient is receiving care to ensure that state medical practice acts, informed consent, and scope of practice laws apply, and that the state has oversight of medical practice.

Providing telehealth services in a "secure environment"

Aside from licensure, the referred item (b) also specifies that telehealth services should be provided in a secure environment, which may be relevant to temporary changes to Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. To help physicians and other health professionals quickly adopt telehealth, the Office for Civil Rights (OCR) announced early in the pandemic that it would exercise discretion in enforcing violations of HIPAA privacy and security rules for physicians and hospitals who, in good faith, utilized telemedicine platforms and applications to connect with their patients. This policy allows health professionals and patients to use technologies that may not meet all HIPAA requirements, such as Skype, FaceTime and Google Hangouts, to provide care. The AMA supported this policy because it helped physicians quickly adopt telehealth without needing to first implement contracts and security reviews that are often complex and time-consuming. However, while HIPAA compliance may seem onerous and burdensome, it is a necessary ingredient to the successful use of telehealth over the long term.

HIPAA's requirements are intended to ensure that both health professionals and their business associates are accountable for the privacy and security of patient information, thereby fortifying the trust that is central to the patient-physician relationship. Accordingly, when the public health emergency ends, the AMA has urged OCR to not continue its enforcement discretion policy, but rather to establish a glide path to compliance with HIPAA obligations. This would mean that, if the emergency ends on September 30, rather than requiring physicians to be fully in compliance on October 1, OCR should instead allow providers to begin taking steps toward compliance (e.g., engage their vendors in discussions about business associate agreements and initiate or implement their security risk analysis of a new telehealth platform). Additionally, the AMA has advocated that OCR should ensure that physicians and other health professionals are held harmless for actions taken in good faith during the public health emergency.

RELEVANT AMA POLICY

A key safeguard included in Policy H-480.946, which was established through Council Report 7-A-14, Coverage and Payment for Telemedicine, stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. The full text of Policy H-480.946 and other relevant policies is appended.

Long-standing AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods (Policy H-480.969). This policy also delineates exemptions from such licensure requirements for "curbside consultations" that are provided without expectation of compensation, and in the event of emergent or urgent circumstances.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 states that our AMA will work with FSMB and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969 states that our AMA will work with the FSMB to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policy D-275.994 supports the IMLC. Policies

H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-480.963 directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

Policy H-130.941 encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and supports the Uniform Emergency Volunteer Health Practitioners Act. Policy H-275.922 encourages FSMB to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state may participate in physician volunteerism in another state.

The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. HIPAA is addressed by Policies H-478.997, D-190.983, and H-315.964.

AMA RESOURCES AND ADVOCACY

Consistent with AMA policy, AMA model state legislation provides a framework for a modern state medical practice act that facilitates physician adoption of telemedicine. The Telemedicine Act clarifies licensure requirements for physicians treating patients via telemedicine, ensuring that, with certain exceptions (e.g., curbside consultations, volunteer emergency medical care), physicians and other health professionals practicing telemedicine are licensed in the state where the patient receives services or are providing these services as otherwise authorized by that state's medical board. The model bill also outlines steps through which a physician can establish a relationship with a new patient via telemedicine and addresses informed consent and privacy.

The AMA has created numerous resources to help guide physician practices through the successful implementation of telehealth, including a Telemedicine Quick Guide, Telehealth Implementation Playbook, and Continuing Medical Education (CME) modules available on the AMA Ed Hub. The AMA has also developed HIPAA privacy and security resources to help walk physicians through what is needed to comply with the required HIPAA privacy and security rules. The AMA Physician Profile Service is used extensively by organizations that verify physician credentials directly (e.g., licensing boards, hospitals, group practices, managed care organizations and physician recruiters).

At the beginning of the pandemic, the AMA also made available a COVID-19 State Policy Guidance on Telemedicine, which outlined AMA policy recommendations for telemedicine on a range of issues, including licensure, in response to COVID-19. As noted previously, the AMA engages in robust federal and state telehealth advocacy and routinely weighs in on a range of telehealth policy proposals related to licensure, payment, coverage, technology and equity. Federal legislation addressing licensure includes the Temporary Reciprocity to Ensure Access to Treatment Act or the TREAT Act (S 168/HR 708), which would provide nationwide temporary licensing reciprocity for telehealth and in-person care during the public health emergency and for 180 days thereafter. The AMA is neutral on this legislation because it specifies that health professionals providing care across state lines will be subject to the jurisdiction of the state in which the patient is located. The Equal Access to Care Act (S 155/HR 688) would allow health professionals in one state to provide telemedicine in states where they are not licensed during the public health emergency and for 180 days thereafter. The site of care in this legislation is considered to be the state where the health professional is located. More broadly, in response to the COVID-19 pandemic the AMA has:

- sought and secured broad telehealth coverage expansion and improved payments at the federal and state levels to increase access to care and provide patients with a safer way to receive care;
- secured introduction of legislation to make key telehealth policy changes permanent; and
- obtained permanent ability to use smart phones for Medicare telehealth services.

DISCUSSION

Once the COVID-19 pandemic was declared a public health emergency, many states quickly waived licensure requirements so that physicians licensed in one state could provide medical care—including via telehealth—to patients in another state. Scores of executive orders and regulatory actions that expanded coverage for and payment of telehealth led to a substantial surge in virtual services, enabling physicians to provide uninterrupted continuity of care amidst stay-at-home orders and helping to ease physician shortages in areas hardest hit by COVID-19. The AMA continues to hear success stories from patients and physicians who view the expansion of telehealth positively and are more comfortable with telehealth than ever before. The Council encourages continued assessment of the experiences of physicians who have used licensing flexibilities to provide telehealth across state lines as well as the impact of virtual services on care quality and patient outcomes. The Council also understands the challenges facing physician practices trying to compete with corporate telehealth entities—including those contracting with payers to provide telehealth—and how these challenges may increase post-pandemic.

The Council is mindful that physicians hold strong, divergent opinions about interstate telehealth and whether the licensure flexibilities put in place during the public health emergency should be made permanent. Some proponents want to abandon the prevailing standard that physicians must be licensed in the state where the patient is located and move toward national licensure and/or federal oversight of interstate telehealth. Other physicians prefer to uphold the state-based licensing structure—which dates to the 1800s and is embedded in state authority granted by the 10th Amendment—and continue treating the location of the patient (originating site) as the site of service. The Council continues to believe that patient safety should remain the primary consideration and that licensure of physicians and other health professionals should remain within the purview of each state. Proposals to change which state is responsible for overseeing the physician from the state where the patient is located to the physician's home state would likewise change which state's medical practice and scope laws apply to the care rendered. Such proposals would interfere with states' investigative and disciplinary authorities and also raise enforcement

concerns since states are generally unable to investigate incidents that happen in another state.[20] Similarly, states cannot take action against the license of a physician in another state.

Considering the differing views among physicians and the issues raised in paragraphs (b) and (d) of the second Resolve of Alternate Resolution 203-Nov-20, the Council focused its deliberations on helping physicians, practices and patients by allowing physicians to treat existing patients wherever they are, thereby preserving those patient relationships, ensuring continuity of care, and permitting specialist care for complex patients and the seriously ill. Consistent with Policy H-480.969, the Council affirmed in its 2019 report that, where there is an established patient relationship, a physician should be able to use telemedicine to provide quality emergent or urgent care for a patient's existing condition when that patient is traveling in another state. In this report, the Council suggests broadening the scope of that statement and address a frustration common among physicians—that they are prohibited by most states from using telehealth to provide longitudinal care to existing patients whom they have seen in the office but who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with FSMB, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met. The Council further recommends amending Policy H-480.969 by addition to codify the previous recommendation in AMA telehealth licensure policy. Because Policy H-480.969 currently prohibits the use of telehealth to provide medical opinions and e-consults between physicians in different states, the Council recommends additional amendments by deletion to update this policy to reflect current practice.

The Council believes these recommendations will increase physician and patient satisfaction with health care, reduce physician licensure-related costs and administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with disabilities or complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians. Additionally, as discussed in Council on Medical Service Report 7-JUN-21, these recommendations have the potential to address long-standing health inequities among marginalized and minoritized communities.

The Council is aware of efforts at the state level to streamline or otherwise facilitate interstate licensure through reciprocity or other means. To ensure that our AMA can support such efforts if they align with existing policy, the Council recommends continued support for state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946. The Council continues to support the IMLC as an important licensure solution and hopes that the states that have not joined the Compact elect to do so. Accordingly, the Council recommends that Policy H-480.946 be reaffirmed. Finally, the Council recommends reaffirmation of Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:
    a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
    b) There is a pre-existing and ongoing physician-patient relationship.
    c) The physician has had an in-person visit(s) with the patient.
    d) The telehealth services are incident to an existing care plan or one that is being modified.
    e) The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed.
    f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. (Directive to Take Action)

2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:

    The Promotion of Quality Telemedicine H-480.969
    (1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
    ~~(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state~~;
    (~~b~~a) exemption from such a licensure requirement for ~~traditional informal~~ physician-to-physician consultations ~~("curbside consultations") that are provided without expectation of compensation~~;
    (~~c~~b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
    (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
    (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current AMA Policy)

3. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)

4. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state

medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. (Reaffirm HOD Policy)

Fiscal Note: Less than $6,000

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Appendix: Relevant AMA Policy

Policy H-480.946, "Coverage of and Payment for Telemedicine"
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.964, “Established Patient Relationships and Telemedicine”
Our AMA will: (1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; and (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, “Coverage of and Payment for Telemedicine.” (CMS Rep. 1, I-19)

Policy H-480.969, “The Promotion of Quality Telemedicine”
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board’s state;
(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation;
(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.
(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the

interstate telemedicine approach adopted must accommodate these essential quality-related functions.
(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.969, "Insurance Coverage Parity for Telemedicine Service"
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19)

Policy H-480.974, "Evolving Impact of Telemedicine"
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of

Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18)

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999
Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Policy D-275.994, "Facilitating Credentialing for State Licensure"
Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission. (Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(JUN-21)

Introduced by: New York

Subject: Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits

Referred to: Reference Committee A

Whereas, According to the AMA Council on Medical Service (CMS), employers and insurance companies are increasingly implementing programs (i.e., Financial Incentive Programs or FIPs) that offer patients financial incentives when they use shopping tools to compare prices on health care items and services and choose lower-cost options; and

Whereas, According to the CMS, empowering patients to pursue health care can minimize financial burden and reduce societal health care costs; and

Whereas, According to the CMS, while considering these potential benefits of FIPs, it is critical to ensure that patients are empowered to make fully informed decisions about their health care, that they are never coerced into accepting lower-cost care if it could jeopardize their health, and that programs that influence patient decision-making should be transparent about quality and cost; and

Whereas, Multiple studies have shown that, on average, Medicaid recipients use emergency rooms (ERs) more often than those with private insurance for non-urgent conditions; and

Whereas, Some states have implicated a copay system in an attempt to deter the overutilization of ERs, but there is concern that such costs have been shown to cause people, especially those within low-income and vulnerable populations, to forgo necessary care; and

Whereas, One multistate study found that charging higher copayments did not reduce ER use by Medicaid recipients and reasons postulated for this finding include that copays are hard to enforce, since ERs are legally obligated to examine anyone who walks through the doors, whether or not they can pay; and

Whereas, One concept that has been implemented in a few states provides Medicaid recipients with a prepaid card to cover a certain number of copays for ER visits and that any unutilized amount on that copay card could be converted to a financial reward at the end of the year; and

Whereas, Some states have set up a 24-hour hotline staffed by nurses who can advise people about whether they are having a true medical emergency; and

Whereas, There is also a compelling need to be very cautious regarding the creation of disincentives for patients who are in need of care; therefore be it

RESOLVED, That our American Medical Association study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or condition instead of hospital emergency departments. (Directive to Take Action)

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

Received: 03/31/21

AUTHOR'S STATEMENT OF PRIORITY

Physicians and other health care professionals understand that Emergency Rooms should be used for true emergency care. The COVID pandemic amply demonstrated that healthcare for patients with non-emergent issues needs to be addressed by alternative health care sites. Physicians and other emergency room personnel need to be able to focus on the life and death situations that present themselves at emergency rooms. Information on what have been successful alternatives for providing care to Medicaid beneficiaries and what incentives have worked to induce Medicaid beneficiaries to use those alternatives will arm health care networks around the country with information to provide better healthcare to that population. By adapting to what works well for the Medicaid population, use of emergency rooms for their intended purpose will improve as will the work environment of physicians and healthcare personnel who work there. Such a report has the power to improve the healthcare for so many.

RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920
1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to

undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.
Citation: CMS Rep. 2, I-19

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
(13) supports increasing public and private investments in home and community-based care, such as adult day care,

assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(JUN-21)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

Whereas, There is some thought about bundling the fees of physicians with those of the hospital in which the services are provided; and

Whereas, Such "bundled" payments will go to the hospital which will then control the payments; and

Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also much more dependent on the hospitals; and

Whereas, Hospitals would similarly never agree to bundled payments that went directly to physicians; therefore be it

RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

New York rates this resolution as a number one priority requiring action to ensure that physicians are compensated fairly and accurately. This issue is vital and affects all physicians who have a relationship of any type with a hospital or hospital system. Physicians have no visibility to bundled payments and cannot therefore verify that their share of a payment is paid properly. Only the hospital would have information about what share of a bundled payment belonged to the appropriate physician or the hospital. The proposed 17% share of the hospital payment is inadequate in terms of payment and does not specify how the bundled payment would be disbursed. Bundled payments to hospitals do not account for how many physicians were involved in the care of a hospitalized patient and would make it very difficult for practices to claim secondary or supplemental benefits under any coordinated benefits the patient might have. This would increase physician stress since income would be affected and increased time would be required on the part of physicians to verify that they are paid fairly. Data used for the purposes of Fairhealth cost estimates could be affected by bundling of payments to hospitals. This issue would have far-reaching consequences if implemented.

RELEVANT AMA POLICY

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.
Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(JUN-21)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance program that allows an eligible employee and his or her dependents the continued benefits of health insurance coverage in the case that an employee loses his or her job or experiences a reduction of work hours; and

Whereas, COBRA allows former employees to obtain continued health insurance coverage at group rates that otherwise might be terminated and which are typically less expensive than those associated with individual health insurance plans; and

Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could occur when a person's employment is terminated; and

Whereas, College students enjoy similar group rate discounts with student health insurance; and

Whereas, These students, upon graduation or other termination of an enrollment, potentially face similar disruption in their healthcare coverage; therefore be it

RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution calls for an important option for recent college graduates who need to retain/obtain health insurance. Most, if not all, once graduated do not have the option of continued coverage under their parent's health insurance due to loss of student status and/or their age. EVERYONE needs to have health insurance and this has been a critically important issue as the COVID pandemic has progressed. While they are seeking employment, it would be beneficial to all if a COBRA-type program existed which would cover these new graduates/ job seekers until they are hired and covered by employer health insurance.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(JUN-21)

Introduced by: New York

Subject: Medicaid Tax Benefits

Referred to: Reference Committee A

Whereas, There are many patients with Medicaid or no health insurance that physicians care for routinely for little or no payment; and

Whereas, It may be politically complicated to rectify this fact directly with improved payments to physicians; and

Whereas, One way to offset the problem would be to use tax deduction techniques; and

Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes providing tax deductions or credits for the provision of care to the medically uninsured and underinsured; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that would allow physicians who take care of Medicaid or uninsured patients to receive some financial benefit through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution and its goals had strong support in the MSSNY House of Delegates. This resolution is particularly important because AMA currently has contrary policy 180.965 that indicates that "the AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured." If AMA is to support physicians, this policy must change.

Physicians are often faced with treatment for patients having no insurance, but physicians can no longer afford to provide care as a charitable act. Payments from Medicaid do not adequately compensate physicians for patient care. Tax credits would provide incentive to continue treating uninsured patients and help to counteract patient care without payment.

RELEVANT AMA POLICY

Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured H-180.965
The AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured.
Citation: BOT Rep. 49, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 141, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(JUN-21)

Introduced by:	Florida, Mississippi, North Carolina, Oklahoma, South Carolina, Virginia, Alabama, District of Columbia, Texas
Subject:	Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums
Referred to:	Reference Committee A

Whereas, The coverage and utilization of telehealth expanded rapidly during the COVID-19 pandemic; and[1]

Whereas, Many commercial health insurance companies have voluntarily expanded telehealth coverage during the pandemic, albeit in some cases on a more restrictive or less generous basis than the Medicare program; and

Whereas, Our AMA has drafted model legislation that requires health insurance companies to offer telehealth coverage and to reimburse for those services “on the same basis and to the same extent” that the insurer would have if the same service were rendered in-person; and[2]

Whereas, There are ongoing discussions across the nation regarding whether to require health insurance companies to offer telehealth coverage and whether to require health insurance companies to provide payment parity for telehealth services; and[3]

Whereas, Physicians have recognized that telehealth can improve clinical outcomes, patient experience, costs, and professional satisfaction; and[4]

Whereas, Insurance companies in Florida and elsewhere have argued that enacting legislation that would require them to offer telehealth coverage and to adhere to payment parity requirements will definitively, significantly increase insurance premiums; and

Whereas, Physician advocates urgently need additional data concerning the effects of telehealth coverage requirements and payment parity requirements on health insurance premiums to respond to the cost-related concerns being propagated by insurers; and

Whereas, Physician advocates may struggle to successfully enact telehealth coverage and payment parity legislation in the absence of research that can be used to respond to the assertion that such legislation will definitively and significantly increase health insurance premiums; and

Whereas, Our AMA is equipped to perform or commission research concerning the effects of telehealth coverage and payment parity requirements, including the effect that such policies may have on health insurance premiums; therefore be it

RESOLVED, That our American Medical Association conduct or commission a study on the effect that telemedicine services have had on health insurance premiums, focusing on the differences between states that had telehealth payment parity provisions in effect prior to the pandemic versus those that did not, and report back at the 2021 Interim Meeting of the AMA House of Delegates. (Directive to Take Action)

Fiscal Note: Estimated cost of $260,000 to implement resolution.

Received: 05/03/21

AUTHORS STATEMENT OF PRIORITY

The practice of medicine would benefit from a study that examined the effects of telehealth coverage requirements, including payment parity requirements, on health insurance premiums.

In the wake of COVID-19, physicians and patients across the nation realized the numerous, substantial benefits of greater access to telehealth. Consequently, state medical societies have become increasingly interested in permanently requiring health insurers to cover telehealth services and to pay for telehealth services at parity with in-person services. The access and patient care benefits of enacting such legislation would be considerable, as the AMA has formally recognized through its public policy positions and ongoing work initiatives.

However, health insurers have expressed opposition to such mandates, arguing that such mandates will significantly increase premiums. Currently, there is a paucity of research examining the effects of telehealth coverage requirements on insurance premiums. This makes it difficult to assess and respond to such claims. Additionally, many state lawmakers are unconcerned about record-high insurance company profits, but care deeply about avoiding legislation that will increase premiums.

Ultimately, even if the scope of the research was limited due to methodological constraints, physician advocates urgently need whatever data can be made available to them. Additionally, even a finding that the effects of such policies on premiums are “inconclusive” would still help physicians respond to claims that increasing access to telehealth will “definitively” and “significantly” raise premiums. In short, this research would help medical societies enact laws that are consistent with AMA policy by supplying advocates with much-needed data.

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2. AMA Telemedicine Model Bill, 2017
3. Kaiser Family Foundation: Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond, https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/
4. American Medical Association Telehealth Research & Key Resources: Research Findings, https://www.ama-assn.org/practice-management/digital/telehealth-research-key-resources-research-findings

RELEVANT AMA POLICY

Insurance Coverage Parity for Telemedicine Service D-480.969
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(JUN-21)

Introduced by: American College of Cardiology, American Society of Echocardiography, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, American Society of Nuclear Cardiology, Texas

Subject: Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

Referred to: Reference Committee A

Whereas, A coronary artery calcium score (CACS) measured by computed tomography is a noninvasive, low-radiation diagnostic test that correlates with cardiovascular outcomes[1]; and

Whereas, Screening with CACS can help guide the course of clinical management in the borderline-and intermediate-risk patients with 10-year cardiovascular risk of 5% to 20%, particularly those with risk-enhancing factors, e.g., chronic kidney disease, metabolic syndrome, an elevated high sensitivity C-reactive protein, a positive ankle-brachial index, or a positive family history[2,3] by the American College of Cardiology and American Heart Association 2019 Primary Prevention Guidelines; and

Whereas, CACS is not covered by insurance except in the state of Texas[4], and the out-of-pocket costs range from $49-$1209, which may represent a barrier for patients who may not be able to afford the test, but are likely to derive benefit from the results of the test; and

Whereas, A low-cost and no-charge CACS strategy has been tested in Cleveland, Ohio[5], demonstrating a striking increase in CACS utilization in lower income patients, the black population and women; therefore be it

RESOLVED, That our American Medical Association seek national and/or state legislation and/or a national coverage determination (NCD) to include coronary artery calcium scoring (CACS) for patients who meet the screening criteria set forth by the American College of Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar covered preventive service, consistent with the current policy in the state of Texas (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who are unable to afford this test, as a means to enhance disease detection, disease modification and management. (Directive to Take Action)

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

Received: 05/03/21

AUTHORS STATEMENT OF PRIORITY

Ethnic inequities in healthcare remain, particularly in cardiovascular disease. Screening for cardiovascular disease could allow earlier intervention and prevention, and should be accessible to and affordable for everyone. Self-pay or out-of-pocket screening tests may be underutilized in socioeconomically disadvantaged areas. We therefore propose 1) a national policy change to include CACS as a first-dollar covered preventive service, as it currently is in the state of Texas, and 2) that hospital systems strongly consider routinely performing this test for no cost/nominal cost in patients who are unable to afford this test, as a means to enhance disease detection, disease modification and management.

This is a top priority resolution because:
1) It fits squarely within our mission and strategic plan to help eliminate health care disparities.
2) It also calls for near-term important action and requires new policy to implement.
3) No current policy exists on this topic, and it is an important issue on which to have policy.
4) AMA action or policy statement will have a positive impact.
5) Negative impact possible if we do not act now.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

Referred to: Reference Committee A

Whereas, Americans entering the workforce currently have from one quarter to one eighth of the average job tenure as workers now aging into retirement[1]; and

Whereas, Trends such as a higher average worker education level and an increasing share of available jobs in industries with shorter-tenured careers are also contributing to increasing worker mobility, likely more so than any generational differences[1]; and

Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40 years, decreasing the collective bargaining power of today's workers to attain benefits such as quality health insurance[2]; and

Whereas, The number of Americans that have employer-sponsored health insurance has declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among low- and middle-income families[3]; and

Whereas, Even among those workers with employer-sponsored health insurance, as many as 25% have out-of-pocket costs so high as to be effectively uninsured[4]; and

Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on employer-sponsored health insurance results in undesirable effects on the American worker such as "job-lock" (being unable to leave a job because of reliance on its health benefits), medical bankruptcy when a patient changes or loses their job while they or a family member requires ongoing medical treatment, and downward pressure on wages[5]; and

Whereas, The predominance of employer-sponsored insurance arose by accident out of an attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of 1942, and was never intended to become the principal form of health insurance in the United States[6]; and

Whereas, As a result of these and other trends, reliance upon a health insurance system tied to employment is becoming increasingly untenable for large portions of the United States population; therefore be it

RESOLVED, That our American Medical Association recognize the importance of providing avenues for affordable health insurance coverage and health care access to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs (New HOD Policy); and be it further

RESOLVED, That our AMA recognize that a significant and increasing proportion of patients are unable to meet their health insurance or health care access needs through employer-sponsored health insurance, and that these patients must be considered in the course of ongoing efforts to reform the healthcare system in pursuit of universal health insurance coverage and health care access. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

This policy position would create discussion around an important weakness in our country that all patients with employer-sponsored healthcare encounter. As we face discussions with the new administration around the future of healthcare, the AMA needs to have a clear answer to whether tying insurance to employment is a requirement for our support as an organization. There is no better way for the AMA to know how to move forward in this advocacy space than to know what our members think by bringing this to the floor of the HOD before a national political fight around healthcare which many members of the Biden administration and congress incorporated into their platforms.

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RELEVANT AMA POLICY

The Future of Employer-Sponsored Insurance H-165.829
Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges
Citation: CMS Rep. 6, I-14

Trends in Employer-Sponsored Health Insurance H-165.843
Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) enhance employee education regarding how to choose health plans that meet their needs;
c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
d) support increased fairness and uniformity in the health insurance market; and
e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.
Citation: CMS Rep. 4, I-07; Reaffirmed CMS Rep. 1, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee A

Whereas, In 2016, the World Health Organization provisionally classified breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma[1]; and

Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that this cancer is a lymphoma; and

Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state clearly that, "Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical excision."[2]; and

Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance companies to cover surgery to remove the cancer and their breast implants, as the insurance company may initially classify the surgery as cosmetic and not cover it;[3] therefore be it

RESOLVED, That our American Medical Association support appropriate coverage of cancer diagnosis, treating surgery and other systemic treatment options for implant-associated anaplastic large cell lymphoma. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

This policy will help bring the spotlight on a disease often overlooked by insurance companies making it harder for this population of patients to cover the costs of their care.

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RELEVANT AMA POLICY
Breast Implants H-525.984
Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.
Citation: CSA Rep. M, I-91Modified: Sunset Report, I-01Reaffirmed: Res. 727, I-02Modified: CSAPH Rep. 1, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(JUN-21)

Introduced by: Illinois

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right[1]; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access[2]; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than $25,000 of annual income having access to internet as opposed to 93.5% of households with over $50,000 of annual income[3,4]; and

Whereas, One in three families who earn less than $50,000 annually do not have high-speed home internet[5]; and

II. Broadband as a social determinant of health

Whereas, The United States Congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications[6]; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream[7,8]; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because “[w]hile factors such as data allowances or pricing may affect consumers’ use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area.”[7]; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health[9]; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health[10-13]; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being[14]; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic[12,13,15,16]; and

Whereas, Our AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that "optimizing the social determinants of health is an ethical obligation of a civil society"; and

III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access[17]; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%; P=0.01), were less likely to be black (24% versus 34%; P<0.01), and had higher median household income (21% versus 32% with income <$50 000, 54% versus 49% with income of $50 000–$100 000, 24% versus 19% with income ≥$100 000)[18]; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country[19]; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care[20,21]; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources[14,20]; and

IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning[5]; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic[20,22]; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones[22]; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic[23]; and

V. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic[24]; and

Whereas, The FCC Lifeline program provides a choice between either discounted mobile internet access or discounted broadband access for qualifying low-income recipients[25]; and

Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile broadband services are full substitutes in all cases[7]; and

Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for approximately 15 of the estimated 21.3 million people that lack home internet access [26,27]; and

Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized program for which there is a significant backlog in applications and delay in application approvals, as well as a lack of an automatic application or automatic appeal process[25]; and

Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still only allows 1 stream of 25mbps per household, limiting access for households with more than one person working/attending school from home[28]; and

Whereas, In the 2020 legislative session as of October 2020, 43 states have considered legislation on broadband access[29]; and

Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered government subsidized free broadband service for COVID impacted people[30,31]; and

Whereas, It is probable that a stimulus package be proposed in the near future, which will likely include internet access as part of this package, between 2020 elections and the next meeting of the AMA House of Delegates[32,33]; and

Whereas, AMA policy H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities sets precedent for the AMA advocating for internet access, and acknowledges the health benefit of internet access, but only asks for expansion of internet infrastructure in rural/underserved communities to provide “connectivity” rather than pushing for universal access to internet for those with significant limitations in access or financial constraints; and

Whereas, Universal coverage of home internet access would increase accessibility to this tool that is critical for patient health and public well-being; therefore be it

RESOLVED, That our American Medical Association recognize that internet access is a social determinant of health (New HOD Policy); and be it further

RESOLVED, That our AMA support universal access to broadband home internet (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to broadband internet, including federal, state, and local funding of broadband internet to reduce price, the establishment of automatic applications for recipients of Medicaid or other assistance programs, and increasing the number of devices and streams covered per household. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This is an urgent issue.

The COVID-19 pandemic created a fast and unexpected growth in telemedicine. This surge in use demonstrates that virtual visits expand access to care, especially for underserved patient populations. However, it is apparent that there can also be digital disparity when patients do not have access to consistent and accessible internet access. If our health care delivery system continues to rely on digital platforms we must ensure that our patients using these tools have the necessary access to universal and consistent internet availability.

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Citation: Res. 021, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their

own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4.Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and

establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(JUN-21)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee A

Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow networks; and

Whereas, These narrow networks often require patients to only see physicians within the county in which the plan was purchased; and

Whereas, Patients are required to purchase a plan based on the county in which they reside; and

Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of choice making their comprehensive plan more of an expensive catastrophic plan; and

Whereas, This limits patient choice by preventing patients from choosing their plan based on access to their physician of choice; therefore be it

RESOLVED, That our American Medical Association advocate for patients to have expanded plan options on the Healthcare Marketplace beyond the current options based solely on the zip code of their primary residence or where their physician practices, including the interstate portability of plans. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The current Healthcare Marketplace plans often have very narrow networks affecting most physicians and their patients by limiting their patients' ability to choose a plan that includes their preferred physician. With patients currently required to purchase a plan based on the county in which they reside, this can result in the patients being unable to see their physician of choice if that physician does not practice in that county even if that physician practices in close proximity to the patient's residence. Ensuring that patients can utilize the physician of their choice is important in maintaining healthy patients who receive the right care at the right time. The AMA has no current policy regarding the expansion of plans that patients can choose from in the marketplace and the AMA is in the best position to advocate for these changes, especially for the many states that currently utilize the federally-run marketplaces. The public health is greatly improved where patients are able to access the physicians they are most comfortable with and this can also improve public health measures such as vaccination rates by improving patient confidence in the care they receive. Finally, with open enrollment typically occurring in late fall, any delay in adopting this policy would delay any possibility of implementing these changes to the marketplace until at least 2022, if not later.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(JUN-21)

Introduced by: Senior Physicians Section

Subject: Towards Prevention of Hearing-Loss Associated Cognitive Impairment

Referred to: Reference Committee A

Whereas, Our AMA holds out as a primary objective "to promote the art and science of medicine and the betterment of public health;" and

Whereas, Our AMA has adopted policy in support of health promotion and preventive care, community preventive services, healthy lifestyles, coverage for preventive care and immunizations, health information and education, training in the principles of population-based medicine, values-based decision-making in the healthcare system, and encouragement of new advances in science and medicine via strong financial and policy support for all aspects of biomedical science and research;[1-8] and

Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation[9] as well as for dementia treatment;[10] and

Whereas, There is mounting evidence that there is a strong link between hearing impairment in middle and later life and the development of cognitive, as well as social impairments and falls, although its specific causality in relation to later cognitive loss has not yet conclusively been established;[11-31] and

Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of 2017, amplified by the 2020 follow-up report[13-15] concluded that age-related hearing loss (ARHL) may account for nine percent of all cases of dementia, making this the single largest potentially modifiable risk factor for that condition, beginning in mid-life; and

Whereas, Compared to individuals with normal hearing, those individuals with a mild, moderate, and severe hearing impairment, respectively, have been shown to have a 2-, 3-, and 5-fold increased risk of incident all-cause dementia over 10 years of follow-up in one study;[29] and

Whereas, Based on prior and pilot studies,[30-31] the causative link between hearing impairment in middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE[32] and other clinical trials now in progress; and

Whereas, The return on investment for hearing remediation, especially but not exclusively in mid-life, will be substantial and time-sensitive insofar as it may ameliorate (by delay in onset or even prevention of cognitive decline) far more costly care for those with cognitive decline (direct and indirect costs). Delaying the onset of Alzheimer's Disease by even one year has significant fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer's disease would save $113 Billion by 2030. This underscores the urgency of current action to reduce the cost of healthcare (including, and perhaps especially, to Medicare) while improving other measures influencing the quality of life;[33-40] and

Whereas, A generally held calculation for the yearly cost of caring for those with dementia exceeds $307 billion as of 2010, and is expected to rise to $624 billion in 2030 and $1.5 trillion by 2050. The current yearly market cost of hearing aids in the US is estimated at $9 billion. This suggests that, with a 9% increase in risk of development of cognitive loss later in life due to unaddressed hearing loss,[13,15] remediating even this single important element linked to cognitive decline would be cost-effective immediately, and will be increasingly so in the future;[39, 40] and

Whereas, The issue of hearing impairment is also a matter of health and social equity, with serious immediate and long-term consequences resulting from neglect of remediation. Unaddressed hearing loss reduces earnings potential and increases disability during gainful years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of hearing amplification and other forms of remediation is significant enough (even with over-the-counter products, which while possibly helpful do not come with professional guidance) to defer purchase and implementation by an indigent population;[46] and

Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention, as well as timely treatment of cognitive impairment and dementia is highly desirable for public health, for humane as well as financial reasons; and

Whereas, Congress has shown initial interest in expanding coverage for hearing remediation in the most recent bill HR 4618, “Medicare Hearing Act of 2019.” The relation of hearing loss to cognitive loss was acknowledged, and the bill passed out of Committee with a favorable recommendation. The bill ultimately failed, but is likely to be refiled in the current Congressional session, affording a strategic opportunity for our AMA to more effectively advocate now for expanding coverage to include coverage of preventive strategies in middle age, promoting that as a way to mitigate future Medicare costs;[41-43] and

Whereas, Some developed countries such as Brazil have launched national efforts to bring hearing remediation to the masses[45] as a means of reducing later cognitive decline, suggesting that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and

Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing remediation are complex, and require physicians to be current, informed, and involved in the discussion with patients;[44,47-48] and

Whereas, a number of groups have a stake in promoting hearing remediation, including professional and citizen organizations and Federal Agencies, such as the Agency for Health Research and Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD); therefore be it

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for increasing hearing screening and avenues for coverage for effective hearing loss remediation beginning in mid-life or whenever detected, including third party insurance coverage, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Unaddressed hearing loss has a major effect on many physicians and patients, especially seniors. Additionally, unaddressed hearing loss has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, an important health care disparity issue for our AMA. Increased hearing screening and remediation is a public health issue that is very consistent with our mission and strategic plan. It is reliably estimated that at 9%, unaddressed age related hearing loss is the single most remediable cause of cognitive decline. Delaying the onset of cognitive decline by even one year has predictably VERY significant societal and fiscal benefits, and thus there is a remarkably negative societal impact for every year that this issue is not effectively addressed.

AMA has significant related policy, but important gaps exist, including education about the connection between hearing loss and cognitive decline, emphasizing the importance of hearing screening at MIDlife, in order to promote remediation, and thereby help to prevent cognitive decline. A few commercial insurers have begun to acknowledge the need. Our AMA must update policy and promote this trend. The proposed action is likely to have meaningful impact but requires new policy or modification of existing policy to implement. There is pending Congressional action that makes this a timely political issue. An AMA resolution is one of the most appropriate avenues to address the issue.

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5. H-425.972 Healthy Lifestyles
6. D-425.996 Implementing the Guidelines to Community Preventive Services
7. H-460.943 Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation
8. H-450.938 Value-Based Decision-Making in the Health Care System
9. H-185.929 Hearing Aid Coverage
10. D-345.985 Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(JUN-21)

Introduced by: Young Physicians Section

Subject: Fertility Preservation Benefits for Active-Duty Military Personnel

Referred to: Reference Committee A

Whereas, According to Pentagon figures, over 200,000 women are in the active-duty U.S. military, including 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in the Marine Corps in 2011;[1] and

Whereas, According to the U.S. Department of Veterans Affairs (VA), there were over 2 million women veterans as of September 2015;[2] and

Whereas, According to the 2012 Committee Opinion on "Health care for women in the military and women Veterans" from the American College of Obstetricians and Gynecologists (ACOG), "military service is associated with unique risks to women's reproductive health …. Obstetrician—gynecologists should be aware of high prevalence problems (e.g., posttraumatic stress disorder, intimate partner violence, and military sexual trauma) that can threaten the health and well-being of these women;"[3] and

Whereas, Both men and women in our U.S. military can suffer from infertility, sometimes directly as a result of blast traumas and spinal cord injuries;[4] and

Whereas, The U.S. Department of Defense (DOD) currently covers the cost of in vitro fertilization (IVF) and infertility services for certain injured active duty personnel;[5] and

Whereas, Under current Tricare policy, active-duty military personnel and their dependents have some limited coverage for infertility care and oocyte cryopreservation services at six specific military treatment facilities: Walter Reed National Military Medical Center in Bethesda MD; Womack Army Medical Center at Fort Bragg in Fayetteville NC; San Antonio Military Medical Center in San Antonio TX; San Diego Naval Medical Center in San Diego CA; Tripler Army Medical Center in Honolulu HI; Wright-Patterson Air Force Base Medical Center in Dayton OH; and Madigan Army Medical Center in Seattle-Tacoma WA;[6, 7] and

Whereas, This critical medical service is not fully available to active duty members of the military and those working with the DOD; and

Whereas, AMA Policy H-150.984 (3)(4) "Infertility Benefits for Veterans" states that: 3)"Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits through TRICARE and the VA at pre-deployment and during the medical discharge process. 4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries";[6] and

Whereas, Fertility preservation for medical indications (such as prior to cancer treatment, organ transplants, or treatment for rheumatologic diseases) are covered under the VA but not covered by the DOD; and

Whereas, AMA Policy H-185.990 "Infertility and Fertility Preservation Coverage," states that: "Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician;"[7] and

Whereas, AMA Policy H-185.922 "Right for Gamete Preservation Therapies" states that: "Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility;" [8] therefore be it

RESOLVED, That our American Medical Association work with interested organizations to encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on this issue at the 2022 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for the AMA to work with relevant specialty societies to ensure TRICARE coverage for fertility preservation. We feel this resolution is important, especially as our brave service members deserve the best of care. However, this impacts a small number of patients and could potentially be addressed by specialty societies. The AMA also has policy on fertility preservation insurance coverage, so could potentially tackle this in DC without this specific resolution if an opportunity presented. While the current Congress is likely more receptive to reproductive health than the ones in the prior administration, we do not feed this is an urgent issue. Therefore, we feel this is a low priority resolution.

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5. "Access to Infertility Care: Challenges and Potential Solutions", by Erin Kramer (ASRM staff), ASRM 10/8/18.
6. AMA policy H-510.984 on "Infertility Benefits for Veterans"
7. AMA policy H-185.990 on "Infertility and Fertility Preservation Insurance Coverage

8. AMA policy H-185.922 on “Right for Gamete Preservation Therapies”
9. AMA policy H-425.967 on “Disclosure of Risk to Fertility with Gonadotoxic Treatment”

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Right for Gamete Preservation Therapies H-185.922
Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility.
Citation: Res. 005, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.
Citation: Res. 005, A-19

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.
Citation: CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19

Health Care for Veterans and Their Families D-510.994
Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.
Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990
Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).
Citation: (Sub. Res.115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Ensuring Access to Safe and Quality Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA supports access to clinical educational resources for all health care professionals involved in the care of veterans such as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.
6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.
Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18; Modified: Res. 305, I-19

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care

within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988
Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.
Citation: Sub. Res. 401, A-10; Reaffirmed in lieu of: Res. 001, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(JUN-21)

Introduced by: Medical Student Section

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right[1]; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access[2]; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than $25,000 of annual income having access to internet as opposed to 93.5% of households with over $50,000 of annual income[3,4]; and

Whereas, One in three families who earn less than $50,000 annually do not have high-speed home internet[5]; and

II. Broadband as a social determinant of health

Whereas, The United States congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications[6]; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream[7,8]; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because “[w]hile factors such as data allowances or pricing may affect consumers’ use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area.”[7]; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health[9]; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health[10-13]; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being[14]; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic[12,13,15,16]; and

Whereas, The AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that "optimizing the social determinants of health is an ethical obligation of a civil society"; and

III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access[17]; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%; P=0.01), were less likely to be black (24% versus 34%; P<0.01), and had higher median household income (21% versus 32% with income <$50 000, 54% versus 49% with income of $50 000–$100 000, 24% versus 19% with income ≥$100 000)[18]; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country[19]; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care[20,21]; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources[14,20]; and

IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning[5]; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic[20,22]; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones[22]; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic[23]; and

V. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic[24]; and

Whereas, The FCC Lifeline program provides a choice between either discounted mobile internet access or discounted broadband access for qualifying low-income recipients[25]; and

Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile broadband services are full substitutes in all cases[7]; and

Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for approximately 15 of the estimated 21.3 million people that lack home internet access [26,27]; and

Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized program for which there is a significant backlog in applications and delay in application approvals, as well as a lack of an automatic application or automatic appeal process[25]; and

Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still only allows 1 stream of 25mbps per household, limiting access for households with more than one person working/attending school from home[28]; and

Whereas, In the 2020 legislative session as of October 2020, 43 states have considered legislation on broadband access[29]; and

Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered government subsidized free broadband service for COVID impacted people[30,31]; and

Whereas, It is probable that a stimulus package be proposed in the near future, which will likely include internet access as part of this package, between 2020 elections and the next meeting of the AMA House of Delegates[32,33]; and

Whereas, AMA policy H-478.980, “Increasing Access to Broadband Internet to Reduce Health Disparities,” sets precedent for the AMA advocating for internet access, and acknowledges the health benefit of internet access, but only asks for expansion of internet infrastructure in rural/underserved communities to provide “connectivity” rather than pushing for universal access to internet for those with significant limitations in access or financial constraints; and

Whereas, Universal coverage of home internet access would increase accessibility to this tool that is critical for patient health; therefore be it

RESOLVED, That our American Medical Association amend policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities," by addition and deletion to read as follows:

INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES, H-478.980

1. Our AMA recognizes internet access as a social determinant of health and will advocate for universal and affordable access to ~~the expansion of~~ broadband and high-speed and wireless internet and voice connectivity, especially in ~~to all~~ rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

2. Our AMA will advocate for federal, state, and local policies to support infrastructure that reduces the cost of broadband and wireless connectivity and covers multiple devices and streams per household. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses the issue of internet access within healthcare and education, especially given the context of the COVID-19 pandemic. Our delegation considers this resolution a priority given our nation's increased usage of internet and need to mitigate rising disparities. The resolution highlights how much of day-to-day healthcare and education access has shifted to an online format. While the United States internet usage has increased 34% between January and April 2020 during the COVID-19 pandemic among families with access to broadband, one in five households with school-age children (ages 6-18) still do not have personal broadband internet access at home during the COVID-19 pandemic.

Moreover, the current administration is considering a $100B proposal for broadband infrastructure. This resolution provides our AMA the opportunity to highlight and support legislation to reduce barriers and increase access to broadband internet to reduce healthcare inequities.

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Res. 208, I-18

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Res. 021, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this

technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation, A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation, A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation, I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(JUN-21)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

Whereas, School based health centers (SBHCs) are facilities located within the academic setting, primarily for those in kindergarten through 12th grade, that provide an array of high quality health care services to students, ranging from primary medical care to dental, vision, and behavioral health services[1]; and

Whereas, SBHCs were originally created to increase access to primary health care and preventative health services, often for the most vulnerable underserved populations[1]; and

Whereas, Due to their focus on preventative care and health maintenance, SBHCs are well suited to address the negative consequences of health disparities in low income urban and rural communities, such as depression, obesity, chronic metabolic issues, which are further associated with poor academic performance[2]; and

Whereas, SBHCs are cost-effective because they increase access to preventive care and reduce utilization of acute care services, leading to a net savings for Medicaid of $30 to $969 per visit[3]; and

Whereas, In a systematic review, SBHCs were also found to substantially reduce the number of ED visits and hospital utilizations[2]; and

Whereas, SBHCs are considered a provider type in only seven states, making it difficult for them to receive proper Medicaid reimbursements[4]; and

Whereas, As a result of difficulties in obtaining Medicaid reimbursements, many SBHCs must rely on public funding to continue to provide important healthcare services[5]; and

Whereas, SBHCs are not differentiated on Medicaid claims data making it impossible to identify what services were rendered by an SBHC versus a different type of provider and thus making it difficult to track and attribute improvements in quality of care or outcomes to SBHCs; and

Whereas, Current AMA policy “supports the concept of … SBHCs” (H-60.921) and recommends minimum standards for school-based health services (H-60.991) but does not support the expansion of these centers or methods to increase funding, therefore be it

RESOLVED, That our American Medical Association promote the implementation, use, and maintenance of school based health centers by amending H-60.921, "School-Based and School-Linked Health Centers," by addition and deletion to read as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.

3. Our AMA supports identifying SBHCs in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA recognizes health care as a human right and strives to increase access through various methods. School-Based Health Centers (SBHCs) are an important tool for providing healthcare for kids in kindergarten through 12th grade, especially for underserved populations. However, it is difficult for SBHCs to bill Medicaid, leading to financial problems for these critical safety nets. Our AMA has previously supported the concept of SBHCs but not addressed their difficulty in obtaining funding. This resolution will amend current policy to support the expansion of these centers, enable future research on quality improvement methods, and enable SBHCs to receive reimbursement from Medicaid. These asks aligns with the AMA's new focus on equity in healthcare and we believe should be considered a priority for the House of Delegates.

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RELEVANT AMA POLICY

School-Based and School-Linked Health Centers H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(JUN-21)

Introduced by: Medical Student Section

Subject: Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration

Referred to: Reference Committee A

Whereas, There are over 2.2 million incarcerated people in the United States[1]; and

Whereas, Incarceration is associated with increased rates of stress-related illness, obesity, infection, and transmission of communicable diseases with resultant increases in mortality, even after adjusting for socioeconomic factors, tobacco and alcohol use, and adverse life events[2-7]; and

Whereas, The Social Security Act currently prohibits the use of federal services such as Medicaid for inmates in jails and prisons unless treatment occurs at an outside institution for at least 24hrs, thereby limiting access to healthcare for the duration of incarceration[8,9]; and

Whereas, 65% of the 10.6 million people admitted to local jails in 2016 were presumed innocent and awaiting trial, signifying that the suspension of federal benefits disproportionately impacts those who cannot afford to post bail in spite of their presumed innocence and thereby contributes to significant disruptions in care[10-12]; and

Whereas, Inmates and their families are charged a variety of fees to help offset correctional costs, including booking, room and meals, hygiene supplies, phone calls, and medical care[13-17]; and

Whereas, Both the Federal Bureau of Prisons and prisons in at least 35 states require a copayment (copay) to access healthcare with the average co-pay across the 50 states being $3.47[13,18]; and

Whereas, Prisoners receive an average minimum wage of only 14 cents per hour with at least 7 states offering no salary at all, thus requiring about 25 hours of work to afford the copayment for medical care[18,19]; and

Whereas, Co-payments that are difficult to afford can prevent prisoners from seeking necessary treatment to the detriment of themselves and of the wider prison population in the case of communicable diseases[20]; and

Whereas, An analysis by Pew Charitable Trusts found that states collectively spent approximately 7.7 billion dollars for inmate healthcare in 2011, and states reported that they only recouped between $190,000 and $500,000 a year from prisoner co-pays, indicating co-pays are not an effective means of offsetting correctional costs while remaining a barrier to accessing care[20]; and

Whereas, Permitting the use of federal services during incarceration could further reduce coverage gaps, minimize the administrative burden associated with suspension/termination, and improve health outcomes[21-24]; and

Whereas, If federal services are made available during incarceration, jails and prisons requesting federal reimbursement would be required to meet appropriate national standards for minimum care pursuant to the Social Security Act[21,25,26]; and

Whereas, Our AMA encourages adoption of national standards to help ensure quality, equitable healthcare for all incarcerated patients (D-430.997); and

Whereas, During the COVID-19 pandemic, Illinois, South Carolina, and California submitted Section 1115 waivers asking to waive the Medicaid inmate exclusion for COVID-19 testing and treatment, with Illinois citing that public health benefits will exceed costs[25,27-29]; and

Whereas, An interruption in insurance coverage also adds to the difficulty of post-release transitions of care and is associated with poor chronic disease management, significant infectious disease transmission, and increased mortality[30-33]; and

Whereas, An estimated 57% of individuals released from prison are either Medicaid-eligible or eligible for federal tax credits under the Affordable Care Act, so disease complications and transmission due to lapses in access to care during and immediately following incarceration incur significant costs to the federal government[34,35]; and

Whereas, Recently incarcerated individuals who are enrolled in Medicaid at time of release are more likely to access and receive community services, have fewer repeat detentions, and greater time between detentions[36,37]; and

Whereas, Permitting the use of federal funding to match inmate health expenses would help states maintain a balanced budget while adequately addressing inmate health needs, as evidenced by estimated annual savings of up to $4.7 billion if Medicaid expansion states are able to cost-share their corrections budgets[38-40]; therefore be it

RESOLVED, That our American Medical Association advocate for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the prohibition of the use of co-payments to access healthcare services in correctional facilities (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-430.986 by addition to read as follows:

HEALTH CARE WHILE INCARCERATED, H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.

~~5~~6. Our AMA encourages states not to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

~~6~~7. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

~~7~~8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

~~8~~9. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

~~9~~10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks our AMA to advocate for people who have been incarcerated to continue to (1) receive federal health insurance benefits both prior to trial and throughout the duration of their incarceration and (2) minimize any co-payments made in prison. It highlights a gap in the coverage of incarcerated individuals and the subsequent impact on treatment of chronic conditions, public health of communities of color, and increased federal government spending as a result of this interruption in federal services.

The topic has its foundations in the AMA's commitment to protecting vulnerable populations, which objectively includes incarcerated persons. Disparities in access to care for vulnerable populations in prison facilities are clearly within the AMA's purview, and there is clearly a strong existing relationship between the AMA and the National Commission on Correctional Health Care which is opposed to copayments. As detailed in this resolution copayments in prison facilities do not appear to add economic value or improve quality in correctional facilities' provision of healthcare, and that the cost of administering these copayment programs is greater than the amount collected, thereby contributing to rather than reducing healthcare costs.

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;
(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.
(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.
(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.
CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
(6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(JUN-21)

Introduced by: Medical Student Section

Subject: Caps on Insulin Co-Payments for Patients with Insurance

Referred to: Reference Committee A

Whereas, Diabetes affects approximately 9.4% of the population and is the seventh leading cause of death nationally[1,2]; and

Whereas, Direct medical costs for diagnosed diabetes were estimated at $327.2 billion in 2017, with nearly $102 billion lost due to lower productivity resulting from diabetes[3]; and

Whereas, The annual average medical cost per person with diabetes is $13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin[4]; and

Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13 cents per unit to 25 cents per unit, translating to a daily cost increase from $7.80 to $15 for a Type 1 diabetic patient using an average amount of insulin (60 units per day)[5]; and

Whereas, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient's prescription drug coverage plan[6]; and

Whereas, Patients who report cost-related underuse were more likely to have poor glycemic control, which is associated with an increased risk for complications such as hypertension, chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression, and cancer[6,7]; and

Whereas, Seven states have approved legislation on insulin copayment caps since April 2020, instituting a $35-$100 maximum copayment for a 30-day insulin supply[8]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin prescription costs through Medicaid Part D for the 2021 plan year to a maximum $35 copay for a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%[9]; and

Whereas, Individual and family savings resulting from caps on insulin copayments have the potential to alleviate financial burden[10]; and

Whereas, The AMA has policy consistent with the principle of increasing access to prescription medications including insulin for patients[11-16]; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers, without any increased cost to their insurance premium or plan[17]; therefore be it

RESOLVED, That our American Medical Association amend policy H-110.984, "Insulin Affordability," by addition and deletion to read as follows:

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies~~.~~; (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Insulin cost and access is a very urgent issue for many of our patients, and we anticipate that this policy may spur state and local efforts to implement copay caps. This resolution asks the AMA to address the issue of rising monthly copayments of insured patients by amending existing policy titled "Insulin Affordability H-110.984." In advocacy, we have seen that drug pricing, particularly insulin prices, is a very active topic in legislation and policy reform. It would be relevant and timely for the AMA to speak on this issue.

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RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities;
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
c. The use of any international drug price index or average should preserve patient access to necessary medications;
d. The use of any international drug price index or average should limit burdens on physician practices; and
e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.
CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Sub. Res. 106, A-15: Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997
Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.
BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation: A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Reducing Prescription Drug Prices D-110.993
Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.
CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation: A-14; Reaffirmed in lieu of Res. 229, I-14

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Res. 211, A-04; Reaffirmation: I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(JUN-21)

Introduced by: Medical Student Section

Subject: Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System

Referred to: Reference Committee A

Whereas, More than 33% of youth entering foster care have a chronic medical condition and up to 80% struggle with significant mental health conditions, requiring sophisticated long-term medical attention well past the age of 18 [1,2]; and

Whereas, Many youths in the foster care system struggle to receive regular health care as they frequently change caregivers and locations, often leading to gaps in their medical and immunization records and poor long term treatment follow through [1]; and

Whereas, Nearly 20,000 children age out of the foster system each year, with the majority leaving with inadequate educational, social and financial support amongst other necessities [3, 4]; and

Whereas, Around 26,000 former foster youth face significant challenges in receiving health care each year [5, 6]; and

Whereas, Children aged out of the foster system are at increased risk for a lifetime of health problems including severe obesity, diabetes, and stroke amongst others due to adverse childhood experiences[7]; and

Whereas, The Affordable Care Act requires states to provide Medicare coverage for youth who have aged out of the foster care system in their state until their 26th birthday [8]; and

Whereas, Currently 37 states interpret the law to require Medicaid coverage for 18 to 26-year-old youths who aged out of the foster care system in their own state, not any other state [8 9]; and

Whereas, AMA policy supports comprehensive, evidence-based care only for children currently in foster care (H-60.910); therefore be it

RESOLVED, That our American Medical Association amend policy H-60.910, by addition and deletion to read as follows:

Addressing Healthcare Needs of <u>Youth</u> ~~Children~~ in Foster Care, H-60.910

<u>1.</u> Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~children~~ <u>youth</u> in foster care.

<u>2. Our AMA advocates that all youth currently in foster care remain eligible for Medicaid of other publicly funded health coverage in their state until at least 26 years of age.</u> (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes health protections and access for vulnerable populations, including youth of the foster care system. This resolution turns AMA's attention to a large, at-risk population needing more consistent access to care, especially with the possibility of anticipated changes in healthcare policy approaches at the federal and state level. Current AMA policy is light on the subjects of transitions of care and foster youth; therefore, this resolution addresses an important policy gap and expands the reach of AMA's advocacy efforts.

While existing resolutions H-60.910 and H-185.929 are broadly inclusive of infants and children, they are not inclusive of aged-out foster care individuals.

This resolution reveals the lack of homogeneity in Medicaid policy: 37 of the 50 states limit coverage to those who have aged-out from the foster care system within their own state. Aged-out individuals across the nation can receive timely detection and treatment for chronic health illness and mental health problems, both of which are reported at higher rates than the general populace. Efforts by the AMA to increase care will also identify those who did not receive appropriate immunization since exiting the foster care system.

The new language will help ensure that all aged-out foster care individuals are supported until the age of 26, regardless of residence. Thus, we urge that our AMA consider this resolution and place this marginalized population on a trajectory towards a better quality of life with physical and mental wellbeing.

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RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.
Res. 907, I-17

Reference Committee B

BOT Report(s)

07 Council on Legislation Sunset Review of 2011 House Policies

14 Pharmaceutical Advertising in Electronic Health Record Systems

18* Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19

Resolution(s)

201 Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication

202 Prohibit Ghost Guns

203 Ban the Gay/Trans (LGBTQ+) Panic Defense

204 Insurers and Vertical Integration

205 Protection of Peer-Review Process

206* Redefining the Definition of Harm

207* Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education

208* Increasing Residency Positions for Primary Care

209* Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research

210* Ransomware and Electronic Health Records

211* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients

212* ONC's Information Blocking Regulations

213* CMMI Payment Reform Models

214* Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities

215* Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs

216* Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies

217* Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19

218* Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity

219* Oppose Tracking of People who Purchase Naloxone

220* Equal Access to Adoption for the LGBTQ Community

221* Support for Mental Health Courts

222* Advocating for the Amendment of Chronic Nuisance Ordinances

223* Supporting Collection of Data on Medical Repatriation

224* Using X-Ray and Dental Records for Assessing Immigrant Age

** Contained in the Handbook Addendum*

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-JUN-21

Subject: Council on Legislation Sunset Review of 2011 House Policies

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

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

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

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

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

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

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

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RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.972	Generic vs Brand Medications	Our AMA will advocate to the US Food and Drug Administration against removal of generic medications from the market in favor of more expensive brand name products based solely on a lack of studies of the efficacy of the generic drug. Citation: Res. 220, I-11;	Retain – this policy remains relevant.
D-100.973	Stricter Oversight of Homeopathic Products by the Food and Drug Administration	Our AMA will urge the US Food and Drug Administration to review the existing regulatory framework for the approval and marketing of homeopathic drug products, including the Compliance Policy Guide, to determine if the current system is sufficient to reasonably ensure the safety and effectiveness of such products. Citation: (BOT action in response to referred for decision Res. 521, A-10; Reaffirmation A-11)	Rescind. FDA issued new draft guidance on Homeopathic products in 2019.
D-130.989	Coverage of Emergency Services	Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition;" (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules. Citation: (Res. 229, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-160.993	Limitation of Scope of Practice of Certified Registered Nurse Anesthetists	Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.	Retain – this policy remains relevant.

		Citation: (Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11)	
D-190.978	HIPAA Privacy Regulations	The AMA will: 1. Not support repeal of the final privacy rule under the Congressional Review Act because the time for Congress to act under that Act has passed. 2. Continue its current strong advocacy efforts to improve and strengthen the final privacy rule while decreasing the administrative burdens it places upon physicians and other health care providers. 3. Partner actively with other relevant groups, such as state and national specialty medical societies, to look for other options for improvement and change and forward these to Department of Health and Human Services Secretary Thompson. 4. Communicate frequently with all interested parties about the progress of this process. Citation: (BOT Action in response to referred for decision Res. 240, A-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. This policy is no longer relevant. There is already a final HIPAA privacy rule.
D-250.988	Support Progress of Science by Addressing Travel Visa Problems	Our AMA will send a letter to the US Department of State explaining the negative impact current visa practices are having on medical and scientific progress and urging policy changes that remove unnecessary barriers in the business and travel visa process that prevent international physicians and scientists seeking to attend US-based medical and scientific conferences. Citation: (Res. 214, I-11)	Retain – this policy remains relevant.
D-265.999	The Right to Know Your Accuser	Our AMA will institute all possible measures on a national level to allow physicians who are subjected to investigations by federal agencies to know their accusers. Citation: (Resolution 220, A-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. This policy has been accomplished. Our AMA wrote a letter to CMS commenting on the new suspension of payment standards. CMS has defined a credible allegation of fraud as: A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline

			complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency (SMA) has reviewed all allegations, facts, and evidence carefully; and acts judiciously on a case-by-case basis. An allegation is now considered credible if the SMA finds that the allegation has evidence of reliability after carefully reviewing all allegations, facts, and evidence. In making credibility determinations, the SMA must act judiciously on a case-by-case basis. CMS has commented that the amount of evidence necessary to support a finding of credibility under the current standard will vary depending on the facts and circumstances surrounding each allegation.
D-270.988	AMA Improve its Transparency, Accountability and Communication	Our AMA will proactively improve its transparency, accountability, and communication by providing rationale for positions to constituent societies and members regarding its actions pertaining to all health care legislation. Citation: (Res. 210, A-11)	Retain – this policy remains relevant.
D-275.964	Principles of Due Process for Medical License Complaints	1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights.	Retain – this policy remains relevant.

		2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. Citation: (Res. 238, A-08; Appended: Res. 301, A-11)	
D-315.981	National Master Patient Identifier	Our AMA, along with other stakeholders, will work with the Office of the National Coordinator for Health Information Technology to develop a strategy for patient identification system at the national level. Citation: (BOT Rep. 23, A-10)	Retain – this policy remains relevant.
D-315.992	Police, Payer and Government Access to Patient Health Information	Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians. Citation: (Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-330.922	Competitive Bidding for Purchase of Medical Equipment by Centers for Medicare and Medicaid Services	Our AMA will: (1) lobby in favor of modification of current Centers for Medicare & Medicaid Services policy to ensure that payments for medical technologies are comparable to market rates; and (2) lobby in favor of moving ahead with the Centers for Medicare & Medicaid Services' plans for a competitive bidding process for home medical equipment and encourage CMS to take into	Rescind. This policy has been accomplished. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the DMEPOS CBP was to be

		consideration quality and patient convenience, in addition to cost. Citation: (Res. 814, I-08; Reaffirmed in lieu of Res. 201, I-11)	phased-in so that competition under the program would first occur in 10 MSAs in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS successfully implemented the Round 1 Rebid in 2011 in select markets and expanded in 2013 for a total of 130 CBAs. After recompeting DMEPOS CBP contracts in these markets, CMS announced plans for Round 2019 in all 130 CBAs. In February 2017, CMS announced that Round 2019 was delayed to allow for reforms to the DMEPOS CBP. Round 2021 of the DMEPOS Competitive Bidding Program began on January 1, 2021 and extends through December 31, 2023. Round 2021 consolidates the CBAs that were included in Round 1 2017 and Round 2 Recompete. Round 2021 includes 130 CBAs. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid
D-330.969	Opposition to Mandatory Hospitalization Prior to Nursing Home Placement	Our AMA shall inform the Centers for Medicare & Medicaid Services that the regulation concerning mandatory hospitalization prior to skilled nursing home placement for Medicare beneficiaries is	Rescind. Our AMA has completed this directive and has more recent and broad policy, including

		obsolete, wasteful of valuable resources and should be abolished. Citation: (Res. 139, A-02; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)	H-280.947, Three Day Stay Rule; H-280.950, Medicare's Three-Day Hospital Stay Requirement.
D-330.979	Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients	Our AMA will petition the Centers for Medicare & Medicaid Services and/or lobby Congress to defeat the "Vitamin D Analogs Draft Local Medical Review Policy" and to prevent its implementation in Florida or any other state. Citation: (Res. 134, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-335.994	Medical Necessity Determinations under Medicare	Our AMA will urge the Centers for Medicare & Medicaid Services and Congress that medical necessity denials within the Medicare program be reviewed by a physician of the same specialty and licensed in the same state. Citation: (Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. This policy has been accomplished. Multiple letters were written to relevant stakeholders (letter 1; letter 2; letter 3) encouraging physician review of medical necessity denials.
D-35.983	Addressing Safety and Regulation in Medical Spas	Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies. Res. 209, I-11	Retain – this policy remains relevant.
D-35.986	Encouraging the AMA to Ask the Robert Wood Johnson Foundation to Substantiate Report Findings	Our AMA will request that the Robert Wood Johnson Foundation: 1) reevaluate the role of advanced practice nurses in the context of a physician-led, patient-centered medical home model; 2) consider the current demographic distribution of advanced practice nurses in independent practice states as an indicator that	Rescind. Our AMA continues to support physician-led teams; created the GEOMAPS (2008, 2014, 2018, 2020) and Health Workforce Mapper to show

	Regarding Nurse Practitioners	there are no true market barriers to competition in health care, rather there are other factors that influence where advanced practices nurses and doctors practice; and 3) require the accuracy of scientific control measures when comparing outcomes of two different care groups, nurse practitioners and physicians. Citation: (Res. 232, A-11)	distribution of non-physicians compared to physicians; continues to urge lawmakers to rely on fact-based data when considering scope expansions.
D-350.988	American Indian/ Alaska Native Adolescent Suicide	Our AMA will: 1) provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native communities; 2) encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native adolescent suicide and make these findings widely available; and 3) lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native adolescent suicide. Citation: (Sub Res. 404, A-11)	Retain – this policy remains relevant.
D-373.996	Possible HIPAA Violations by Law Firms	Our AMA will encourage the Office for Civil Rights of the Department of Health and Human Services to investigate the activities of entities, including Consumer Injury Alert, with regard to possible Health Insurance Portability and Accountability Act (HIPAA) violations and solicitations of lawsuits, and to take whatever action may be legally permissible and fiscally affordable to stop such possible violations and solicitations. Citation: (Res. 217, I-11)	Retain – this policy remains relevant.
D-375.988	Local Peer-Review and Physician Sponsorship Requirements from Medicare QIO Work	Our AMA supports efforts in Congress to reverse the Medicare QIO program structure changes in HR 2832 related to physician involvement in state level QIO work, maintain the statewide scope of QIO contracts, assure the continuation of the beneficiary complaint process and quality improvement efforts at the state level, and maintain the essential local relationships that QIOs must have with physicians and other providers. Citation: (Res. 832, I-11)	Retain – this policy remains relevant.
D-375.991	IOM Report on QIO Program	Our AMA will advocate that: (a) the medical review duties currently included in the Medicare Quality Improvement Organization (QIO) scope of work continue to remain the responsibility of the federally designated QIO in each state through the	Retain – this policy remains relevant.

		end of the current Eighth Scope of Work on into the Ninth Scope of Work and beyond; and (2) medical review of physicians continue to be performed by physicians taking into account both cultural competency and local conditions. Citation: (Res. 726, A-06; Reaffirmed: Res. 832, I-11)	
D-375.998	Peer Review Protection for Physicians Covered by the Federal Tort Claims Act	Our AMA will work with the Indian Health Service headquarters, Public Health Service, and the Department of Health and Human Services Office of the General Counsel to enact federal legislation protecting the confidentiality of peer review/clinical quality assurance information done by physicians and organizations covered by the Federal Tort Claims Act. Citation: (Res. 230, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-375.999	Confidentiality of Physician Peer Review	Our AMA will draft and advocate for legislation amending, as appropriate: (1) the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act; and (2) the Health Care Quality Improvement Act to prohibit discovery of information obtained in the course of peer review proceedings. Citation: (BOT Rep. 22, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-385.962	AMA Statement to FTC, CMS and OIG DHHS Supporting the Ability of ACOs to Negotiate with Insurers on an Exclusive Basis	Our AMA will clarify its support of antitrust relief for physician-led accountable care organizations (ACOs), as stated in its September 27, 2010 statement to the Federal Trade Commission, the Centers for Medicare & Medicaid Services, and the Office of Inspector General of the US Department of Health and Human Services, as being limited to physician-led ACOs and not to ACOs owned and controlled by non-physicians, including hospitals, insurance companies, or others. Citation: (Res. 830, I-10; Reaffirmed: Res. 215, A-11)	Rescind. This policy has been accomplished. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Faco-antitrust-reform-proposal-comment-letter.pdf
D-390.957	A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act	Our AMA will now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the 2010 Interim Meeting of the House of Delegates through AMA Policy D-390.960. Citation: (Res. 203, I-11)	Retain – this policy remains relevant.

D-435.970	Expert Witness Certification	1. Our AMA will immediately assist all interested state medical associations in initiating similar legislation as recently passed in Florida to require physicians licensed in another state to obtain an expert witness certificate before being able to provide expert witness testimony in medical liability actions, and that state physician licensing boards be empowered to discipline any expert witness, both those licensed in that state and those with an expert witness certificate, who provide deceptive or fraudulent expert witness testimony. 2. Our AMA will continue to provide updates on our AMA Web site regarding the progress that has occurred in the implementation of expert witness legislation in states throughout the United States. Citation: (Res. 203, A-11)	Retain – this policy remains relevant.
D-440.939	National Diabetes Clinical Care Commission	Our AMA will actively work to secure congressional enactment of a National Diabetes Clinical Care Commission. Citation: (Res. 223, I-11)	Rescind. This policy has been accomplished. The National Clinical Care Commission Act (Pub. L. 115–80) required the HHS Secretary to establish the National Clinical Care Commission, which has conducted activities since 2018.
D-450.966	American Health Care Access, Innovation, Satisfaction and Quality	Our AMA will begin an international comparative study on health care quality that is a comprehensive and balanced study including comparisons of patient satisfaction, cancer outcomes, outcomes among more severe illnesses and injuries, rapidity of access and patient satisfaction as end points, and present their findings to the AMA House of Delegates at the 2012 Annual Meeting. Citation: (Res. 104, A-11)	Rescind. Aspects of this policy continue to be addressed in articles published in JAMA, Health Affairs, Kaiser Family Foundation, World Health Organization, and several other sources.
D-460.972	Creation of a National Registry for Healthy Subjects in Phase I Clinical Trials	Our AMA encourages the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in Phase 1 trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and to document previous trial participation. Citation: (Res. 913, I-11)	Retain – this policy remains relevant.

D-460.973	Comparative Effectiveness Research	Our AMA will solicit from our members and others articles or postings about current clinical topics where comparative effectiveness research should be conducted and will periodically invite AMA members to recommend topics where the need for comparative effectiveness research is most pressing, and the results will be forwarded to the Patient-Centered Outcomes Research Institute (PCORI) once it is established, or to another relevant federal agency. Citation: (Res. 221, A-11)	Retain – this policy remains relevant.
D-478.979	Promoting Internet-Based Electronic Health Records and Personal Health Records	Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR. Citation: (BOT Rep. 11, I-11)	Rescind. Most people are not using PHRs in the way envisioned when this policy was first adopted. The movement now is for smartphone apps to essentially function as PHRs. In that sense, our AMA continues to work with multiple agencies to minimize risks, educate about implementation barriers, and promote best practices, etc., more focused on apps rather than other types of PHRs.

G-615.070	COL Activities	AMA policy on the activities of the Council on Legislation include the following: (1) All medical legislative issues should be cleared through the COL before action is taken by any other AMA council or committee, and the Board shall take whatever action is appropriate to achieve this objective; (2) The Council shall continue to refer issues to other committees and councils for advice and recommendations, when said issues properly fall within their sphere of knowledge and activities; (3) The Board shall be advised of the Council's desire to maintain constant surveillance of legislative matters; (4) The Council shall have authority to recommend to the Board the initiation of specific legislation or legislative policy to meet current problems confronting physicians or our AMA; and (5) The Board shall be advised of the Council's willingness and ability to testify before congressional committees or to accompany the principal witnesses who may testify on behalf of the Association. Citation: (COL/BOT Rec., I-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)	Retain – this policy remains relevant.
H-120.951	Mandatory Acceptance of the Currently Utilized Physician Prescription Form by Pharmacy Benefit Plan Administration	Our AMA seeks legislation or regulation that would: (1) require that pharmacy benefits plans accept the currently utilized physician prescription forms for all initial prescriptions and renewals; and (2) ensure that a written, oral or electronically transmitted prescription that complies with state and federal law constitutes the entirety of the physician's responsibility in providing patient prescriptions. Citation: (Res. 516, A-02; Reaffirmed: BOT Rep. 8, A-11)	Retain – this policy remains relevant.
H-120.999	Refilling of Prescriptions	The AMA supports pursuing through the proper state or federal enforcement agencies full compliance with the laws, and if no law applies, supports legislation to carry out the following criteria: (1) any prescription not labeled as to number of refills may not be refilled; and (2) any prescription labeled PRN or ad lib may not be refilled.	Retain – this policy remains relevant.

		Citation: (Res. 46, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11)	
H-150.998	Food Additives	Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market. Citation: (Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10)	Retain – this policy remains relevant.
H-160.929	Anesthesiology is the Practice of Medicine	It is the policy of the AMA that anesthesiology is the practice of medicine. Our AMA seeks legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry. Citation: (Sub. Res. 216, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-175.973	Medicare Investigation Search and Seizure Process	(1) It is the policy of our AMA that: (1) no duly authorized law enforcement or legal agency conduct any unannounced search of physicians' offices or seizure of records without observance of appropriate legal procedures; (2) should unannounced search and seizure procedures be warranted in emergency situations based on clear and immediate threats to the lives or physical well-being of patients or the general public, such searches/seizures be conducted within the following parameters: (a) the search and/or seizure shall be conducted in a non-threatening and thoroughly professional manner; (b) the search and/or seizure shall not disrupt patient care; (c) the search and/or seizure shall be conducted in a manner to avoid publicity injurious to a physician's practice and professional reputation until all facts are known and culpability, if any, can be proven; (3) When an episode occurs whereby a governmental agency disrupts the daily activities of a physician's office in the process of investigating alleged fraud and abuse activities, that such	Retain – this policy remains relevant. Update Clause 3 so reports are directed to the AMA Advocacy unit since there is no longer a separate Division of Private Sector Advocacy.

		episodes be reported to the ~~Division of Private Sector~~ AMA Advocacy unit for tracking purposes and to assist the involved/affected physician(s); and. (4) If abusive practices of the investigative agency are noted, the AMA will inform the Department of Justice of those tactics. Citation: (Res. 205, I-01; Reaffirmed: BOT Rep. 22, A-11)	
H-175.977	Disruptive Visits to Medical Offices by Government Investigators and Agents	Our AMA: (1) supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office; (2) in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff in a quiet and confidential way that allows the physician an opportunity to comply in a manner that is least disruptive and threatening to the patients in the medical office; and (3) encourages physicians to report incidents of inappropriate intrusions into their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation. Citation: (Res. 211, A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-175.979	Medicare "Fraud and Abuse" Update	Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors. Citation: (BOT Rep. 34, I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-175.981	Fraud and Abuse Within the Medicare System	(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.	Retain – this policy remains relevant.

		(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies. (3) The burden of proof for proving fraud and abuse should rest with the government at all times. (4) Congressional action should be sought to enact a "knowing and willful" standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation. (5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens. Citation: (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: BOT Rep. 6, A-00; Reaffirmation I-01; Modified: CMS Rep. 7, A-11)	
H-175.987	All-Payer Health Care Fraud and Abuse Enforcement Program	Our AMA: (1) opposes an All-Payer Health Care Fraud and Abuse Enforcement Program described in the Health Security Act of 1993 as it specifically applies to the seizure of property as a punitive measure in health care fraud cases; (2) supports efforts to clearly define health care fraud and establish an intergovernmental commission to investigate the nature, magnitude and costs involved in health care fraud and abuse; and (3) will pursue enactment of laws that ensure the equal application of due process rights to physicians in health care fraud prosecution. Citation: (Res. 215, A-94; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. The Health Security Act of 1993, S. 491, was introduced but never passed. However, Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS)

			acting through the Department's Inspector General (HHS/OIG). The HCFAC program is designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse.
H-180.955	Deductibles Should Be Prorated to Make Them Equitable for Enrollees	Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. Citation: (Res. 235, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-190.961	Repeal of Federally Mandated Uniform Medical Identifiers	Our AMA: (1) actively supports legislation that would repeal the unique patient medical health identifier mandated by the Health Insurance Portability and Accountability Act of 1996; and (2) urges all state medical societies to ask each of their congressional delegations to declare themselves publicly on this matter. Citation: (Res. 207, I-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. Policy D-315.981, National Master Patient Identifier, is recommended to be retained (see above) and more broadly calls for our AMA to develop a strategy for a patient identification system at the national level.
H-215.962	Maintain CMS Inpatient Rehabilitation Classification Criteria at 60%	Our AMA: (1) reaffirms existing AMA policy and supports continuation of the compliance threshold for inpatient rehabilitation hospitals at its current level of 60 percent; and (2) strongly opposes any increase in the compliance threshold for inpatient rehabilitation hospitals. Citation: (Res. 212, I-11)	Retain – this policy remains relevant.
H-240.960	Opposition to Equalization of Payment Rates for Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	Our AMA will oppose legislative or regulatory efforts to equalize payments for more medically complex rehabilitation patients with greater functional deficits, who require more intensive rehabilitation in an Inpatient Rehabilitation Facility, compared to less medically complex rehabilitation patients with fewer functional deficits, who require less intensive rehabilitation at a Skilled-Nursing Facility, regardless of their specific medical diagnosis. Citation: (Res. 213, I-11)	Retain – this policy remains relevant.
H-270.956	Evidence-Based Standard Requirement for	Our AMA supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate	Retain – this policy remains relevant.

	Governmental Regulation	the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded. Citation: (BOT Rep. 7, A-11)	
H-270.964	Fraud Compliance and Compliance Plans	Our AMA express its strong objections to the OIG for its unwarranted punitive attitude and the financial and administrative burden to physician practices and seeks modification to the final version of the "Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" so that it is not burdensome nor costly to medical practices (with respect to physician, staff, administrative, and financial resources) and focuses on education rather than criminal punishment. Citation: (BOT Rep. 29, A-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. Our AMA is, and will continue to, engage with the OIG to oppose policies that negatively impact individual and small group physician practices. The Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" is no longer on the OIG website, and has been replaced by a "Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud Abuse." Although the guidance document does provide information on penalties, the tone is more focused on education.
H-270.999	Legislation Making the Federal Register Give Fairer and More Reasonable Notice of the Promulgation of Regulations Which Will Have the Force of Law	Our AMA (1) is concerned over the lack of opportunity to develop and submit appropriate comments on proposed regulations, especially in the Federal Register, without adequate notice; and (2) supports (a) taking appropriate action to obtain greater advance notice and opportunity to comment on proposed regulations; (b) consideration of appropriate means to make available for the profession information concerning significant proposals of the various federal agencies on health matters; and (c) development of mechanisms to provide for more effective relief from the implementation of regulations harmful to sound medical practice should comments adverse to such regulations be ignored. Citation: (Sub. Res. 152, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report,	Retain – this policy remains relevant.

		A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-285.939	Managed Care Medical Director Liability	AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. (1) Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; (2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability. Citation: (Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07; Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11)	Retain – this policy remains relevant.
H-290.977	Medicaid Sterilization Services Without Time Constraints	Our AMA will pursue an action to amend federal Medicaid law and regulations to remove the time restrictions on informed consent, and thereby allow all patients, over the age of 21 and legally competent, to choose sterilization services. Citation: (Res. 226, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-295.947	Legislative Threats to the Voluntary Accreditation Process	It is the policy of the AMA to strongly oppose legislation which would: (1) dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education; and (2) limit professional participation in the setting and evaluation of quality standards in medical education. Citation: (Res. 225, I-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.

H-305.962	Taxation of Federal Student Aid	Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). Citation: (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain – this policy remains relevant.
H-305.997	Income Tax Exemption for Medical Student Loans and Scholarships	The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. Citation: (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. This issue is addressed in H-305.962, Taxation of Federal Student Aid.
H-330.918	Violation of Medicare Act	Our AMA will take all measures to oppose any provision in the Medicare law and regulations that permits inappropriate federal involvement in medical treatment decisions or control over the practice of medicine as prohibited by Section 1801 of the Social Security Act. Citation: (BOT Rep. 37, I-98; Reaffirmation A-99; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.943	Physicians' Rights	Our AMA: (1) in conjunction with CMS, will seek to develop a simple, straightforward statement of a health care professional's or a provider's rights when initially under investigation for alleged fraud or abuse; and (2) urges that, where records or other information are requested from hospitals or other sources by a Medicare carrier fraud and abuse unit and where the investigation does not yield a potential case referable to the Office of the Inspector General, those sources from which information was sought and the involved physicians and others should be notified of their absolution after such an investigation. Citation: (Substitute Res. 212, I-94; Reaffirmation A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.948	Three Day Prior Hospital Stay Requirement	Our AMA will recommend that the Secretary of the U.S. Department of Health and Human Services, in consultation with health care professionals and skilled care providers, define a subset of patients (or DRGs) for whom the elimination of the three-day prior hospital stay requirement for eligibility of the Medicare Skilled Nursing Facility benefit would avert hospitalization and generate overall cost savings.	Rescind. This policy is not relevant as our AMA has advocated more broadly to eliminate the three-day hospital stay requirement for SNFs.

		Citation: (Res. 805, I-93; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-04; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)	
H-330.964	Federal Budgetary Process Reform as It Affects Medicare	Our AMA seeks legislative reform of the federal budgetary process to remove last-minute changes in Medicare funding in the reconciliation budget process and to insure appropriate and timely public input. Citation: (Res. 177, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.988	Free Choice by Patient and Physician Guaranteed	Our AMA reaffirms the original intent of Title XVIII, Section 1802 of the Social Security Act, which guarantees free choice by patient and physician. Citation: (Res. 115, I-87; Reaffirmed: Res. 731, A-95; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-335.962	Recovery Audit Contractors Should Confirm Problem Has Not Already Been Resolved Before Undertaking an Audit	Our AMA advocates that Federal Recovery Audit Contractors (RACs), prior to instituting an audit of a physician practice, make a good faith effort to ascertain whether the practice has already self-identified any billing irregularities that may have resulted in overpayments (including any such overpayment that may have been reported to the RAC), and has satisfactorily cured the irregularities by returning the overpayments and making any needed changes in their billing procedures, and where such self-identification and rectification has already occurred, that the audit not be initiated. Citation: (Res. 214, A-11)	Retain – this policy remains relevant.
H-335.984	Medicare Regulatory Relief Legislation	It is the policy of the AMA to initiate modifications to the Regulatory Relief Amendments or introduce additional legislation to address further areas where unwieldy or inequitable federal regulations or legislation place unrealistic or unfair demands on physicians and their office staff to: (1) abolish the A/B Data Link in which physician services provided during inpatient treatment, where payment to the hospital has been denied, are reviewed and can be denied as medically unnecessary years after the treatment has been provided; (2) abolish the practice of downcoding claims where Medicare carriers arbitrarily alter physician claims so that physicians are paid for a lower level of service than the one actually provided;	Retain – this policy remains relevant.

		(3) further clarify Section 6109 of OBRA 1989 that nullified the recoupment of funds from Texas physicians and patients so that the original intent of the legislation would be realized through repayment of funds to those physicians and beneficiaries who had already repaid funds to the government; (4) include provisions that relieve patients and physicians of responsibility for implementation of the Medicare as a Secondary Payer provisions and that the Medicare carrier be charged with responsibility for obtaining payment from the proper insurer rather than from physicians or beneficiaries for any errors that may be made in the determination of a beneficiary's insurance status; and (5) include provisions that would nullify Section 6102(g)(4) of OBRA 1989 that all Medicare claims be filed by physicians so that physicians who have large numbers of claims for small amounts would not be burdened with the transaction costs of meeting the mandatory claims filing provision, particularly since the OBRA 1989 provisions explicitly forbid physicians from requesting or receiving any additional payment for this costly and time-consuming service. Citation: (Res. 213, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-340.900	Quality Improvement Organization Program Status	Our AMA urges implementation of a Medicare beneficiary complaint process under the Medicare Quality Improvement Organization Program that meets the information needs of patients, offers appropriate due process for physicians, and maintains confidentiality of review findings. Citation: (CMS Rep. 1, A-97; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.917	Publication in Federal Register of Proposed Changes in QIO Review Process or Procedures	Our AMA strongly urges CMS to publish in the Federal Register for review and comment any significant proposed changes in the quality improvement organization (QIO) process or procedures which would affect physician practice patterns and/or the delivery of medical care. Citation: (Sub. Res. 710, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.

H-340.930	~~Peer Review~~ Quality Improvement Organization Sanctions	Our AMA supports vigorously pursuing with appropriate ~~peer review~~quality improvement organizations (1) the careful definition of an adverse event, (2) the identification of whether the event is avoidable or unavoidable and whether it is a recognized complication of diagnosis or treatment, and (3) whether the event establishes a pattern or trend pointing to inappropriate physician or institutional behavior. Citation: (Res. 185, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain part of the policy. The Medicare Peer Review Organization program was renamed the Quality Improvement Organization program. Modify the title and policy by replacing "peer review" with "quality improvement."
H-340.931	Unannounced Enforcement of Regulation	Our AMA petitions CMS to preclude application of a law, rule or regulation prior to its effective date and urges CMS to announce the date on which the enforcement of a law, rule or regulation applicable to the Medicare program will begin. Citation: (Res. 199, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.932	Time Restrictions Placed on QIOs to Implement Changes in Review Procedures	Our AMA supports working with CMS to assure that quality improvement organizations are given adequate time for proper implementation of mandated changes to review processes and procedures. Citation: (Res. 95, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.933	QIO Data Dissemination	Our AMA discourages the use of any QIO data by any hospital, medical staff or other body for credentialing purposes. Citation: (Res. 249, A-91; Modified: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.972	Office of the Inspector General Involvement in ~~Peer Review~~ Quality Improvement	The AMA supports (1) careful review of the involvement of the Office of Inspector General in ~~peer review~~quality improvement organization and other sanction activity against physicians based on the quality of care provided; and (2) taking all appropriate steps, including legislative action if necessary, to establish a fair review mechanism designed to ensure that quality of care determinations are medically correct. Citation: (Res. 67, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 7, A-11)	Retain part of the policy. The Medicare Peer Review Organization program was renamed the Quality Improvement Organization program. Modify the title and policy by replacing "peer review" with "quality improvement."

H-35.970	Doctor of Nursing Practice	1. Our American Medical Association opposes participation of the National Board of Medical Examiners in any examination for Doctors of Nursing Practice (DrNP) and refrain from producing test questions to certify DrNP candidates. 2. AMA policy is that Doctors of Nursing Practice must practice as part of a medical team under the supervision of a licensed physician who has final authority and responsibility for the patient. Citation: (Res. 214, A-08; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-35.973	Scopes of Practice of Physician Extenders	Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care. Citation: (Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-35.974	Prescribing by Allied Health Practitioners	Our AMA will work with national specialty societies to monitor the status of any initiatives to introduce legislation that would permit prescribing by psychologists and other allied health practitioners, and develop in concert with state medical associations specific strategies aimed at successfully opposing the passage of any such future legislation. Citation: (Sub. Res. 203, A-02; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-35.982	Direct Access to Physical Therapy	Our AMA (1) affirms that the ordering of medical services for patients constitutes the practice of medicine and that legislation to authorize non-physicians to prescribe physical therapy and other medical care services should be opposed; and (2) encourages physicians who prescribe physical therapy to closely monitor their prescriptions to ensure that treatment is appropriate. Citation: (Res. 203, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: Res. 224, A-11)	Retain – this policy remains relevant.

H-35.993	Opposition to Direct Medicare Payments for Physician Extenders	Our AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician. Citation: (CMS Rep. N, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-355.979	National Practitioner Data Bank	It is policy of the AMA to improve patient access to reliable information and as an alternative to a federally operated national data repository, our AMA strongly supports and actively encourages the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies Our AMA: (1) supports requiring felony convictions of physicians to be reported to state licensing boards; (2) supports federal block grants that provide states with sufficient financial resources to develop and implement officially recognized, Internet accessible, physician-specific information systems that will assist patients in choosing physicians; and (3) believes that serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence. Only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action. Citation: (BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain – this policy remains relevant.
H-365.986	US Efforts to Address Health Problems Related to Agricultural Activities	Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities. Citation: (Res. 212, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain – this policy remains relevant.
H-385.918	Urging CMS to Direct Carriers	Our AMA will: (1) urge the Centers for Medicare & Medicaid Services to direct its carriers to effect	Rescind. This policy has been accomplished. Our

	to Effect Mass Retroactive Claims Adjustments	mass retrospective claims adjustments at the rates issued by Congress in the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act, and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010; and (2) urge Medicare contractors to ensure corrected payments are issued to physicians going forward so that physicians receive the full benefit of the increased reimbursement rates as soon as possible. Citation: (Res. 231, I-10; Reaffirmed: Res. 216, A-11)	AMA repeatedly urged CMS to proceed with the retroactive processing of claims as instructed by the Affordable Care Act. As a result of AMA advocacy, CMS finally moved forward with the processing of the claims.
H-385.950	Managed Care Secondary Payers	Our AMA: (1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries; (2) will require that these co-insurance and deductible obligations cannot be waived contractually; ~~(3) will develop model state legislation that would mandate that all secondary insurers to Medicare either pay their contracted physicians full Medicare deductible and coinsurance amounts regardless of whether their fee schedules are lower than Medicare, or allow physicians to bill Medicare beneficiaries directly for the full Medicare deductible and coinsurance amounts;~~ (4<u>3</u>) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage; (~~5~~<u>4</u>) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service; (~~6~~<u>5</u>) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient	Retain part of the policy. Delete Clause (3) and renumber Clauses 4-7 accordingly. Our AMA has developed model legislation called for in Clause (3).

		deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to "manage" the Medicare benefit, as if the secondary carrier were the primary carrier; and (~~7~~6) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient's primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer. Citation: (BOT Rep. 33, A-96; Appended: Res. 122, A-98; Reaffirmed: Res. 105, A-00; Sub. Res. 104, A-01; Reaffirmation I-01; Appended: Res. 105 and 106, A-03; Appended: Res. 821, I-11)	
H-390.971	Hospitals Limited to Participating Physicians	Our AMA (1) advises its members that the decision of whether or not to be a "participating" physician in Medicare is a personal choice; (2) supports use of all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers and which jeopardize the quality, availability and affordability of health care for the aged and the infirm; (3) urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: "Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." "Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to	Retain – this policy remains relevant.

		participate under this title if such institution, agency, or person undertakes to provide him such services;" (4) supports rescinding the "incentive" in OBRA 1986 regarding hospital referral of Medicare patients to participating physicians; (5) supports amendment of the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and (6) supports rescinding OBRA 1986 provision that requires a nonparticipating physician who performed an elective surgical procedure on an unassigned basis for a Medicare beneficiary to provide the beneficiary in writing the estimated approved charge under Medicare, the excess of the physician's actual charge over the approved amount, and the coinsurance applicable to the procedure. Citation: (Res. 31, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	
H-420.978	Access to Prenatal Care	(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account. Citation: (Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11)	Retain – this policy remains relevant.
H-425.973	CMS Should Provide Date Eligibility Information to Beneficiaries	Our AMA encourages the Centers for Medicare & Medicaid Services to establish user-friendly mechanisms, such as an automated phone-in system or a web portal, much as is currently provided by banks, including of course appropriate measures to ensure security and confidentiality, via which any Medicare beneficiary can easily and quickly verify the dates of eligibility for all preventative services to which the person is entitled.	Retain – this policy remains relevant.

		Citation: (Res. 213, A-11)	
H-425.978	Stroke Prevention and Care Legislation	Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of stroke prevention and care. Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-435.945	Binding Arbitration	Our AMA supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution. Citation: (Res. 229, A-11)	Retain – this policy remains relevant.
H-435.962	Tort Reform and Managed Care	AMA policy states that medical liability reform be construed in the context of managed care and be consistent with these objectives: that (1) all managed care organizations (MCOs) are held responsible for assuring quality healthcare, and are held liable for any negligence on the part of the health plan resulting in patient injury; (2) physicians know and are able to carry out their professional obligations to patients despite cost constraints and contractual obligations to MCOs; and (3) coordinated patient safety systems tailored to managed care arrangements are in place. Citation: (BOT Rep. 18, I-96; Reaffirmation I-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed in lieu of Res. 224, A-09; Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11)	Retain – this policy remains relevant.
H-435.972	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	The AMA will continue to address the need for effective nationwide tort reform through the AMA's coalition-building activities and efforts on behalf of state and federal tort reform. Citation: (BOT Rep. M, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed in lieu of Res. 205, I-11)	Retain – this policy remains relevant.
H-435.974	Support of Campaigns Against Lawsuit Abuse	Our AMA supports expanding its tort reform activities by assisting state and county medical societies and interested civic groups in developing and implementing anti-lawsuit abuse campaigns and by encouraging members to involve themselves in these campaigns.	Retain – this policy remains relevant.

		Citation: (Res. 223, I-91; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11)	
H-450.934	Timely Access to Health Insurance Plan Claims Data	Our AMA will: 1) advocate for appropriate policies, legislation, and/or regulatory action that would require third-party payers engaged in risk or incentive contracts with physician practice entities (including IPAs, PHOs, ACOs, healthcare networks, and healthcare systems) to provide physicians with timely access to reports of initial claims for service for patients served by those risk or incentive contracts; 2) advocate that third-party payers be required to make available electronically to physician practice entities reports of initial claims for service for patients served by risk or incentive contracts immediately upon such claims being received by the payer; and 3) advocate that third-party payers be required to make immediately available to physicians any relevant data on their patients collected in furtherance of risk profiling or incentive contracts that affect the safety or quality of patient care, in a form that permits efficient searching and retrieval. Citation: (Res. 220, A-11)	Retain – this policy remains relevant.
H-450.971	Quality Improvement of Health Care Services	Our AMA will continue to encourage the development and provision of educational and training opportunities for physicians and others to improve the quality of medical care. Citation: (BOT Rep. I, I-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain – this policy remains relevant.
H-460.931	Genetics Testing Legislation	The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing. Citation: (Sub. Res. 219, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CEJA Rep. 6, A-11)	Retain – this policy remains relevant.
H-460.953	Biomedical Research and Animal Activism	Our AMA: (1) supports working through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research and will work with Congress and the USDA to	Retain – this policy remains relevant.

		ensure that needs and views of patients and the scientific community are heard during any further consideration of USDA's role in laboratory animal oversight; and (2) supports laws which make it a federal crime, and similar legislation at state levels to make it a felony, to trespass and/or destroy laboratory areas where biomedical research is conducted. Citation: (Res. 238, A-91; Appended: Res. 513, I-00; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)	
H-460.975	Support for NIH Research Facilities	Our AMA urges: (1) the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities; (2) that the authority be granted to the NIH Director and not fragmented at the categorical institute level; and (3) that institutions be required to match federal funding for this program in a systematic way. Citation: (BOT Rep. S, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – this policy remains relevant.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-JUN-21

Subject: Pharmaceutical Advertising in Electronic Health Record Systems

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Interim Meeting Policy D-478.961, "Pharmaceutical Advertising in Electronic Health Record Systems," was adopted by the House of Delegates (HOD). The policy directs our American Medical Association (AMA) to study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in electronic health record (EHR) systems.

This report provides information about the prevalence and ethical implications of direct-to-physician pharmaceutical advertising, with specific attention to advertisements and alerts in the EHR.

BACKGROUND

Pharmaceutical companies have a long history of marketing to physicians in the clinical setting. In recent years access to physicians has become more challenging for pharmaceutical companies—nearly half of physicians restrict visits from pharmaceutical sales representatives.[1] Perhaps making up for the decline in direct access, the amount of money spent on marketing and advertising to physicians continues to increase. Pharmaceutical companies spent $20.3 billion on marketing to physicians in 2016 through advertisements, samples, direct payments, personal visits and gifts from pharmaceutical representatives, up from $15.6 billion 20 years earlier.[2] Spending on advertising in digital channels such as search engines and social media platforms also continues to increase.[3] The EHR system has risen as a unique opportunity to directly provide information about prescription drugs to prescribers, given that physicians spend more than 15 minutes per patient in the EHR.[4] However, there are ethical concerns with pharmaceutical advertising in the EHR, and whether this is a common practice or a sustainable business model for EHRs has yet to be explored.

AMA POLICY

The AMA supports the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people (Policy H-100.995, "Support of American Drug Industry"). In addition, the AMA supports a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices (H-105.988, "Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices").

AMA *Code of Medical Ethics* Opinion 9.6.7, "Direct-to-Consumer Advertisements of Prescription Drugs," states physicians should remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products. The Opinion also states physicians should

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resist commercially-induced pressure to prescribe tests, drugs, or devices that may not be indicated. Although this Opinion does not specifically address physician-directed pharmaceutical advertisements, the substance and meaning are applicable. Similarly, *Code of Medical Ethics* Opinion 9.6.2, "Gifts to Physicians from Industry," asserts that gifts from industry, including pharmaceutical organizations, can create conditions in which professional judgment can be put at risk of bias. This Opinion suggests that to preserve the trust that is necessary in patient care, physicians should decline gifts from entities that have a direct interest in physicians' treatment recommendations. AMA policy also states that no gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices (H-140.973, "Gifts to Physicians from Industry").

In Policy H-175.992, "Deceptive Health Care Advertising," the AMA encourages physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising that is false and/or deceptive in a material fact and encourages medical societies to keep the Association advised as to their actions relating to medical advertising.

To mitigate adverse effects of pharmaceutical advertisements on women's health, the AMA also urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex (Policy D-105.996, "Impact of Pharmaceutical Advertising on Women's Health).

DISCUSSION

Pharmaceutical industry influence on physicians

Pharmaceutical companies spend billions of dollars every year trying to influence physicians through a variety of tactics. For decades, physicians have been a prime target for pharmaceutical advertisers, made evident by the frequent placement of ads in medical journals. Pharmaceutical companies historically have had a presence in physician offices through visits by sales representatives, gifts, drug samples, sponsorship of continuing medical education, token items such as notepads and pens, and more valuable incentives such as travel or dinners. This access to physicians gave these companies key opportunities to influence physicians' prescribing behaviors.

Although they still accept payments, gifts, samples, and other incentives from pharma, most physicians do not believe they are affected by pharmaceutical industry interactions and believe they are immune to the influence of their marketing strategies.[5] Multiple studies, however, have found associations between exposure to information provided by pharmaceutical companies and higher prescribing frequency, higher costs, or lower prescribing quality.[6] For example, exposure to physician-directed advertising has been shown to be associated with less effective, lower-quality prescribing decisions.[7] This evidence suggests that some physicians, particularly those faced with interactions with pharmaceutical advertising, are susceptible to influence by various types of interactions with pharmaceutical companies, whether it be from gifts, payments, sponsorships, drug samples, travel, or research funding. These interactions can influence physicians' clinical decision making, potentially leading to greater prescriptions of certain types of drugs.[5]

Pharmaceutical influence on physician decision-making was tested in a case study by Merck, which partnered with Practice Fusion in a public health initiative to test the incorporation of EHR messages alerting each provider during a patient visit when the patient might be due for a vaccine.[8] The message alerts, while not considered formal advertisements, suggested specific treatment to

prescribers in an intervention group at the point of care, demonstrating that the alerts functioned primarily to influence prescriber behavior. The test program, which included more than 20,000 health care providers divided into intervention and control groups, led to a 73 percent increase in recorded vaccinations and the administration of more than 25,000 additional vaccines. Whether the increase in vaccinations is a positive outcome is not the question to be debated in this report; however, the appropriateness of the pharmaceutical company's influence in the decisions about patient care should be questioned.

Prevalence of advertising in the EHR

One health care marketing agency that focuses in part on pharmaceutical clients described the EHR as an opportunity to influence the prescribing decision with advertisements. In its report, they describe banner advertisements within the administrative or consultation workflow as reminders that can be targeted by physician specialty, geography, past prescribing behavior, patient demographic, current therapy, or diagnosis. Their report continues, "When a [health care provider] is reached in a clinical prescribing environment, the opportunity to impact behavior is greater." The agency recommends prioritizing the moment within either the health records or e-prescribing interface that is most meaningful based on brand objective.[9] It is clear from these descriptions that the patient-physician visit, particularly a vulnerable moment such as the discussion of medications, is viewed by pharmaceutical marketers as an opportunity for financial gain.

It is estimated there are currently more than 300 EHR system vendors in the U.S.[10] The vast number of EHR products makes it challenging to determine the exact number of ad-supported EHRs. It is known to pharma marketers that the largest EHRs do not have a business model that supports advertising.[9] Physician advisers to the AMA were consulted about the presence of advertisements in the top five EHR systems, which comprise 85 percent of the market share.[11] None were aware of advertisements featured in these commonly used platforms. There may be a small portion of the remaining 15 percent of EHR platforms that generate revenue through ads, but currently only a handful offer partnerships with pharmaceutical companies.[10]

Considering the volume of information required in pharmaceutical advertisements to health care professionals, as regulated by the FDA[12], pharmaceutical manufacturers and advertisers may look for other means by which to promote their products at the point of care. In addition to traditional banner ads, there are points of interaction between a prescriber and the EHR throughout the clinical encounter that present opportunities for promotion of specific pharmaceuticals, such as clinical decision support (CDS) alerts in the patient information screens. Information about specific drugs may also appear during the prescribing workflow in an e-prescribing system.

Practice Fusion, a San Francisco-based company that was purchased by Allscripts in 2018, was a free EHR software that provided space for pharmaceutical text and banner ads within certain screens of the EHR.[13] Practice Fusion was found to be the market share leader for solo and small practices in 2015.[14] In a broad search of articles about free or low-cost EHRs featuring an ad-supported revenue model, Practice Fusion is repeatedly referenced as the prime example and is the only EHR consistently mentioned throughout the literature.

Although many articles referenced Practice Fusion in positive light and touted it as an innovative solution to the decrease in access to physicians, they all pre-dated recent legal developments involving Practice Fusion. In early 2020, after months of federal investigation, Practice Fusion admitted to soliciting and receiving kickbacks from a major opioid manufacturer, later discovered to be Purdue Pharma, in exchange for CDS alerts that promote unnecessary opioids at the point of prescribing in their EHR system.[15] The Pain CDS in Practice Fusion's EHR displayed alerts more

than 230,000,000 times between 2016 and 2019. Health care providers who received the Pain CDS alerts prescribed extended release opioids at a higher rate than those that did not,[16] suggesting that the alerts succeeded in influencing prescribing behavior.

This activity by Practice Fusion demonstrates how the EHR can present opportunities for stakeholders to abuse the system, inappropriately influence physicians' decisions, and put patients at risk. The practice of generating revenue by placing advertisements in the EHR was a key feature of the system developed by Practice Fusion. Like the CDS alerts, the ads were tailored to display information about specific drugs, using patient and physician data and targeting the prescriber at the point of care. This ad-supported business model was abandoned by Practice Fusion in 2018 after its purchase by Allscripts.[17]

The literature search conducted in writing this report showed no evidence that ad-supported EHRs have a significant presence in the EHR market or are on the rise. There was little to no mention of specific ad-supported EHRs other than articles written about Practice Fusion, suggesting this single company, which is now virtually defunct, had the bulk of this market captured. The conduct of Practice Fusion and its extreme consequences may, for other EHR providers, put into question prospective partnerships with pharmaceutical companies and slow potential growth in adoption of ad-supported models.

Advertising in other physician-facing channels

Sometimes during patient encounters physicians require just-in-time education or review of drug indications, dosage, interactions, contraindications, and pharmacology at the point of care. Prescribers may consult with peers and medical experts, search for and read about drug information in an authoritative medical journal, or simply search online for relevant information. In addition, point-of-care medical reference applications, such as Epocrates or Medscape Mobile, provide easy access to drug prescribing and safety information that physicians can use quickly during a patient visit. These applications often feature advertisements for pharmaceutical products. Seventy percent of Epocrates' revenue is from selling point of care pharmaceutical advertising, in the form of "DocAlerts."[18] Anecdotal feedback from physician users of Epocrates suggests that while they appreciate using the app at no cost, they do question the appropriateness of the advertisements.[18,19]

Ethical implications

Advertising at the point of care, through EHRs or other mechanisms, carries the risk of influencing physician judgment inappropriately and undermining professionalism, which may ultimately compromise quality of care and patient trust. While there are few data yet available about the specific influence of advertisements in EHRs, studies do suggest that distributing sample medications to physicians' offices, an indirect form of such advertising, does affect physicians' treatment recommendations in ways that can be problematic. For example, data suggest that physicians who have access to samples prefer prescribing brand name drugs over alternatives, even when the branded sample is not their drug of choice or is not consistent with clinical guidelines. Moreover, as one article has noted, physicians may be "less aware of when they are encountering digital marketing than they are with traditional marketing."[20]

Advertising at the point of care can undermine physicians' ethical responsibility "to provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment."[21] Whether a physician prescribes a medication or device should rest "solely on medical considerations, patient need, and reasonable expectations of effectiveness for the particular patient."[22] By influencing decision making, such advertising can

also undermine physicians' responsibility to be prudent stewards of health care resources and to "choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources."[23]

There are emerging regulations at the state and federal levels that will require prescription cost information to be visible in the EHR at the point of prescription. While the AMA is largely in support of drug price transparency, and has clear policy encouraging EHR vendors to include features that facilitate price transparency (D-155.987, "Price Transparency"), the availability of this information at the point of care has the potential to influence a prescriber's decision. This potential influence and its effects on prescriber patterns should be considered in future study.

While physicians have a clear ethical responsibility to ensure safe, evidence-based care, developers of EHRs also have ethical responsibilities to patients. The stated goal of electronic records is to facilitate seamless patient care to improve health outcomes and contribute to data collection that supports necessary analysis[24]—not to serve as a vehicle for promoting the interests of third parties. Practices and health care institutions that deploy EHRs have a corresponding responsibility to ensure that their record systems are directed in the first instance to serving the needs of patients.

Implications for patient safety

Studies of advertising in EHRs were not identified at the time of writing this report, so it is premature to describe or quantify associated patient safety risks. However, physician-directed pharmaceutical advertising has been commonplace in medical journals for decades, and there is an abundance of research about the implications for patient safety and ethics of such ads. Pharmaceutical advertisements, including those in medical journals, are regulated by the Food and Drug Administration (FDA). A 2011 cross-sectional analysis of medical journals evaluated the adherence of these advertisements to FDA regulations. The analysis showed few physician-directed journal advertisements adhered to *all* FDA guidelines and over half of them failed to quantify serious risks of the advertised drug.[25] Given the high risk associated with many advertised drugs, and the observation that many ads do not adhere to FDA regulations or disclose known risks, any propensity of pharmaceutical ads to influence prescribing—regardless of the channel—may pose threats to patient safety. Thus, it is up to the physician or prescriber to base their prescribing decisions on clinical evidence and sound judgment, rather than marketing tactics.

The Practice Fusion scheme is a prime example of an EHR vendor allowing commercial interests to take precedence over patient safety. Although CDS tools are not advertisements in the traditional sense, if the drug information in the CDS popup is presented in a way that the prescriber has little choice but to view the product displayed, it is in effect an advertisement. The U.S. Department of Justice highlighted the risk to patient safety in its January 2020 press release. "During the height of the opioid crisis, the company took a million-dollar kickback to allow an opioid company to inject itself in the sacred doctor-patient relationship so that it could peddle even more of its highly addictive and dangerous opioids. The companies illegally conspired to allow the drug company to have its thumb on the scale at precisely the moment a doctor was making incredibly intimate, personal, and important decisions about a patient's medical care, including the need for pain medication and prescription amounts."[26]

Implications for physician and patient data privacy

There are important implications for the privacy of physician prescribing data and patient data when it is used by advertisers to provide timely patient-specific advertisements. If an EHR vendor

is collecting and sharing prescribing patterns of an individual physician, or even specific patient information, with the pharmaceutical company, this invites the risk of physician and/or patient data misuse. Currently, there is little known about what data is being collected for this purpose, to whom it is being provided, and how it is being used.

The AMA published privacy principles that define what it considers appropriate guardrails for the use of patient health information outside the traditional health care setting. The principles shift the responsibility for privacy from individuals to data holders, meaning that third parties who access an individual's data should act as responsible stewards of that information, just as physicians promise to maintain patient confidentiality.[27] It is AMA's position that these principles apply to any entity that collects, retains, and uses patient and/or physician prescribing data for marketing and other purposes.

CONCLUSION

Although some EHRs and e-prescribing programs may present opportunities for advertisers to inappropriately influence patient care, they appear to have a small presence in today's EHR market. And while pharmaceutical companies continue to advertise to physicians through other digital channels, such as journals or medical reference applications, prescribers should continue to provide care and prescribe treatments using evidence-based information and their best judgment, and practices should be intentional in deploying systems that function primarily to serve patient care. There is little evidence that ad-supported EHR systems are highly prevalent or gaining popularity. However, where pharmaceutical advertisements *are* present at the point of care, they can present significant threats to patient safety and the integrity of patient care. In addition, it is evident that despite prescribers' best intentions there are instances in which decision-making can be influenced by external factors such as CDS alerts or advertisements. Considering the information presented in this report, it is recommended that AMA establish policy opposing the practice of pharmaceutical advertising in electronic systems used at the point of care and continue to monitor the practice in the future.

RECOMMENDATIONS

The Board of Trustees recommends that Policy D-478.961 be amended as follows and the remainder of the report be filed:

Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical and promotional content in medical reference and e-prescribing software, unless such content complies with all provisions in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices (H-105.988); and (3) encourages the ~~federal government to~~ study of the effects of direct-to-~~physician~~prescriber advertising at the point of care, including advertising in ~~Electronic Health Record Systems~~ (EHRs~~)~~, on physician prescribing, patient safety, data privacy, health care costs, and EHR access for ~~small~~physician practices.~~; and (2) will study the prevalence and ethics of direct-to-physician advertising at the point of care, including advertising in EHRs.~~

Fiscal note: Less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-JUN-21

Subject: Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

The COVID-19 pandemic has had devastating health consequences and caused widespread, serious disruption in the U.S. and worldwide. As of May 2021, there have been more than 32 million cases of COVID-19 in the U.S. and 576,238 COVID-19-related deaths. In 2020, the estimated age-adjusted death rate increased 15.9 percent compared with 2019 and COVID-19 was the underlying or a contributing cause of 377,883 deaths; COVID-19 death rates were highest among males, older adults, and American Indian/Alaska Native, Hispanic, and Black persons.[1] According to the National Center for Health Statistics, COVID-19 was the third leading underlying cause of death in 2020, replacing suicide as one of the leading causes of death.[2]

The use of vaccine credentialling and/or mandatory vaccination has been urged to speed the return to "normal." Although existing AMA policy provides guidance on routine vaccinations, COVID-19 and COVID-19 vaccines present unique and challenging circumstances for which additional policy is needed.

DIGITAL VACCINATION CREDENTIAL SERVICES (DVCS)

With more people getting vaccinated and a strong desire from the public to return to "normal" life, many companies are developing digital vaccine credential services (DVCS), often referred to by the misnomer "vaccine passports."[1] The term DVCS collectively refers to a digital vaccine credential issuer, a digital vaccine credential app/platform, or a digital vaccine credential requestor. A vaccine credential issuer refers to those who administer vaccines to individuals (e.g., physician offices, hospitals). A digital vaccine credential app/platform is the technology an individual would use to obtain a digital credential stating they have been vaccinated (i.e., a digital form of paper vaccination record). A digital vaccine credential requestor is any entity that seeks to view and possibly utilize the digital credential for some purpose (e.g., a sports venue that will only admit individuals who possess digital vaccine credentials).

Requiring proof of vaccination is not a novel concept in this country; for example, most jurisdictions require students to provide proof of vaccination prior to attending not only elementary and secondary schools, but also higher education and childcare facilities. Additionally, international travel often requires proof of vaccination against certain communicable diseases.

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[1] AMA prefers the term "vaccine credential" to the frequently used "vaccine passport." The latter is misleading and its purposes can be misunderstood. Passports are legal documents issued by nations to control entry and exit from a country and may also be used as legal identification. Vaccine credentials, in contrast, are medical documents that document an individual's vaccination status. See Benjamin GC, *Vaccine Passports Are a Premature Solution to a Challenging Problem* (April 19, 2021) available at https://leaps.org/vaccine-passports-are-a-premature-solution-to-a-challenging-problem/particle-1.

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Clearly these are specific use cases that do not apply to the country's entire population. DVCS, however, may be utilized by hundreds of millions of people across society depending on the scope of digital vaccine credential requestors planning to require digital vaccine credentials for entry into or participation in certain events, facilities, and venues, helping to reduce transmission and at the same time allowing participants to signal that they mutually share the protection of each having been vaccinated. Some envision DVCS potentially serving as a "critical driver for restoring baseline population health and promoting safe return to social, commercial, and leisure activities."[3] There are already nearly 20 DVCS in development, and multiple states and other jurisdictions have developed their own DVCS.[4]

DVCS may provide multiple benefits that paper records do not. For example, paper records can be lost. They may also require individuals to make additional trips to physician offices or pharmacies to pick up copies of their vaccination records, which can be burdensome to both the patient and practice. Nor is it clear how individuals who received vaccine at mass vaccination events can obtain records after the event. Moreover, patients receive vaccinations at different stages throughout their lives Additionally, paper vaccination records can be stolen or fraudulently produced—something already happening with COVID-19 vaccination cards.[5] Accordingly, DVCS potentially serve as a reliable, convenient, and accurate mechanism by which one can demonstrate and verify their vaccination status. The DVCS seek to authentic vaccination status by providing a direct, electronic way to trace back where the information came from (a concept in health information technology known as provenance).

The use of DVCS is not without potential pitfalls, however. Some challenges are practical, such as ensuring that DVCS can successfully access source data stored in different formats, whether hardcopy or electronic, among the many entities that are providing COVID-19 vaccination. Significant questions remain around the ethics of DVCS usage, support, and mandates.[6] Some states have or are attempting to ban the use of DVCS outright, reinforcing political divisions over COVID-19 vaccination.[7] Even though the Biden administration has stated that it will not develop a federal DVCS, the AMA believes there is still an important role for the federal government to play in establishing, publicizing, and enforcing guidelines to which all DVCS must adhere.[8]

First, the use of DVCS must not outpace vaccine availability. Although supplies are rapidly increasing, vaccines are not yet universally accessible, particularly to individuals in historically marginalized and minoritized communities. Until all Americans are easily able to access vaccines and trusted DVCS, we must guard against programs that appear to confer special social privilege based on one's COVID-19 vaccination status. Additionally, the pandemic has demonstrated our country's stark disparities in access to technology, inequitable technology innovation and design priorities, and digital literacy. A DVCS must ensure that individuals can access their credentials in hard copy. Relatedly, both access to DVCS and DVCS functionality, content, and user interface must be designed with and for historically minoritized and marginalized communities. DVCS must address issues of culture, language, digital literacy, and access to broadband services to ensure that the tools are usable by all individuals and do not de facto discriminate.

Second, most of the digital vaccine credential apps/platforms individuals may use to obtain their digital vaccine credentials will not be subject to any sort of federal privacy protections (including the health sector specific privacy law, the Health Insurance Portability and Accountability Act of 1996 [HIPAA]). The AMA has advocated very strongly in recent years that the use of apps outside of HIPAA—despite their potential to improve individual access to one's own health information—pose a significant threat to the privacy of such information.[9] Failure to address the lack of privacy requirements in apps can also stymie the uptake of innovative technologies that could potentially improve public health. Such failure, along with concern about surveillance, lack of coordination,

and distrust of technology companies contributed to sluggish adoption of digital contact-tracing apps early in the pandemic.

Vaccine credentialing apps are likely to face similar concerns regarding privacy, surveillance, and apprehension. Specifically, individuals subject to disproportionate rates of incarceration and heightened surveillance based on immigration status or race; those with stigmatized health conditions such as substance use disorder, HIV/AIDS, and other sexually transmitted infections; LGBTQ individuals; unhoused people; and individuals with disabilities may be wary of DVCS due to the possibility that third parties will share their data with employers, insurers, landlords, the police, or other government agencies. Accordingly, the AMA recommended that the federal government develop guidelines around data governance, including (but not limited to) utilization of classic data privacy principles such as data minimization (i.e., only collecting the minimum amount of information necessary to function as a credential), data sunset rules (i.e., discarding data once it is no longer needed), and data sharing defaults that require users to opt-in to broader, automatic data sharing (as opposed to forcing users to take additional steps to opt-out of such sharing).

Lastly, DVCS policy is likely to shift as vaccine availability increases and scientific evidence of effectiveness or limitations grows.[10] DVCS will need updates to accommodate these changing requirements. No one organization, app marketplace, or industry will be able to track, monitor, and provide individuals meaningful information on credentialing services, including data use policies or app adherence to development principles. Individuals should have access to a single source of truth where they can clearly understand features, functions, and the policies by which apps abide. Accordingly, the AMA has recommended that DVCS register with the federal government after meeting the above-described federal guidelines and be included on a public-facing list of all registered DVCS along with clear and understandable information about each DVCS.

VACCINE MANDATES

As supplies of COVID-19 vaccines become available to meet demand vaccine hesitancy is high, leading to doubt that the U.S. will be able to achieve "herd immunity,"[11] there have been calls for mandating vaccination, especially for frontline health care workers, first responders, or others considered essential workers, and students.[12] Mandates are legal and enforceable for interventions that have been licensed by the U.S. Food and Drug Administration (FDA), but there are questions about whether that is also the case for interventions released under an Emergency Use Authorization (EUA), as COVID vaccines were initially.[13,14] However, Pfizer/BioNTech recently submitted a Biologics License Application (BLA) for their COVID-19 vaccine, asking for expedited review and it is expected that FDA will soon grant a BLA.[15]

Vaccine mandates serve a fundamentally different purpose from DVCS: where DVCS offer individuals opportunity to resume at least a semblance of "normal" activities in the absence of herd immunity,[16] mandates are promoted precisely as a means to achieve that immunity. The primary intent of a mandate is to protect the health of the community, with benefit to the individual secondary. Like DVCS, vaccine mandates raise concerns about equity, but given the different goal to which they are directed, they do so in a somewhat different way. DVCS ease restrictions on individuals but may unfairly exclude those who would choose to be vaccinated but cannot access vaccine. Mandates intentionally impose restrictions by obviating personal choice and requiring everyone to be vaccinated, with only limited exceptions, when voluntary uptake does not reach levels that will achieve the public health goal of herd immunity. Importantly, privacy is less a concern with respect to vaccine mandates than are issues of autonomy.

Historically, public health restrictions have been imposed on individual autonomy in the interest of protecting the health of the community, and the legality of state-imposed vaccine mandates is well-established. Since the landmark case *Jacobson v. Massachusetts* in 1905, the law has generally favored states' ability to exercise the police power to compel vaccination "as the safety of the general public may demand" even at the expense of individual liberty.[17]

All states currently employ vaccine mandates in some form, most in alignment with the recommendations of the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP). As noted previously, all states require students to provide proof of vaccination for specified vaccines before they are permitted to attend school. Many require staff of health care institutions, public and private, to be vaccinated for a range of infectious diseases, including seasonal influenza, to protect patients, staff, and the broader community. All states permit medical exemptions for individuals who have contraindications for vaccinations. Some allow parents or guardians to opt out of vaccination requirements if they object on the basis of religious beliefs (44 states), or personal, moral, or other beliefs (15).

Mandates that allow non-medical exemptions are problematic. AMA policy supports eliminating such exemptions, and further recommends that states have processes in place to determine which vaccines will be mandatory for admission to school and other identified public venues and that such mandates be based on ACIP recommendations.[18] Policy also recognizes that health care workers have strong obligations to accept vaccination voluntarily, particularly for vaccine preventable diseases that are or may become epidemic or pandemic that pose significant medical risk or threaten the availability of the health care workforce.[19] AMA policy further encourages use of mechanisms to encourage vaccine uptake, such as providing vaccination at no cost for employees, up to and including making vaccination a condition of employment.[20]

Research has demonstrated that vaccine mandates, and the elimination of non-medical exemptions to those mandates, are effective at increasing immunization rates. COVID-19 vaccination is a critical prevention measure to help end the COVID-19 pandemic. The three COVID-19 vaccines currently authorized by the FDA for emergency use and recommended for use in the U.S. population by the CDC as recommended by the ACIP have been shown to be effective against SARS-CoV-2 infections, including the prevention of severe disease and death. According to the CDC, as of May 7, 2021 about 45 percent of the total U.S. population have received one dose of vaccine and about 33 percent have been fully vaccinated.[21] However, the number of administered vaccine doses is decreasing. There are currently five SARS-CoV-2 variants of concern circulating for which there is evidence of an increase in transmissibility, more severe disease, significant reduction in neutralization by antibodies generated during previous infection or vaccination, reduced effectiveness of treatments or vaccines, or diagnostic detection failures.[22]

Whether it is ethically acceptable for public or private entities to mandate vaccination as a condition of access to employment; education; or other activities, goods, or services requires thoughtful balancing of multiple considerations, including how readily the disease in question is transmitted; what medical risk the disease represents for individuals and the community at large; how risks of exposure are distributed across the population; the safety and efficacy of available vaccine(s); the effectiveness and appropriateness of vaccination relative to other strategies for preventing disease transmission; the medical value or possible contraindication of vaccination for the individual; and the prevalence of the disease. The more readily transmissible a disease and the greater the risk to those with whom an infected individual comes in contact relative to risks of vaccination, the stronger the argument for mandatory vaccination. Given the high rate of asymptomatic transmission in COVID-19, vaccinating the greatest number of individuals possible is critical. Yet despite their effectiveness as public health tools, vaccine mandates are a blunt

instrument and may carry the risk of further eroding trust and ultimately undermining public health goals.

Mandates are inherently coercive and have the potential to impose burdens unequally across communities. For example, employer mandates that put livelihoods at risk may be especially onerous in communities where opportunities for employment are limited. The COVID-19 pandemic has already had devastating effect among marginalized and minoritized communities for individuals who have had no choice but to accept the risk of disease to preserve their livelihoods. Moreover, mandating vaccination may further alienate individuals who are mistrustful of authority, of vaccines generally, or of COVID-19 vaccines specifically even while it serves important public health goals. They should therefore be implemented with these considerations in mind and efforts made to minimize the potential to exacerbate existing inequities and adversely affect marginalized and minoritized communities to the extent feasible.

If successful in increasing vaccine uptake, efforts to promote voluntary vaccination would better respect recipients' autonomy and minimize the potential to impose disproportionate burdens on marginalized and minoritized communities. For example, Maryland is now offering $100 to state employees who are fully vaccinated for COVID-19, while West Virginia is offering $100 savings bonds to young residents to get vaccinate and Connecticut is partnering with a restaurant trade group to offer free drinks at certain restaurants for residents who have been vaccinated.[23] However, data are not yet available to indicate whether such efforts might be effective in persuading enough individuals to seek vaccination voluntarily that the U.S. could avoid the need to mandate vaccination to control the spread of COVID-19.

With respect to health care professionals, guidance in the AMA Code of Medical Ethics provides that physicians have a professional ethical responsibility to be vaccinated, absent medical contraindications, and enjoins physicians who are not vaccinated for whatever reason to voluntarily take steps to protect patients, fellow staff, and the public, including refraining from direct patient contact.[24] Guidance further delineates the responsibilities of health care institutions to protect patients and staff from epidemic or pandemic disease, such as providing and requiring use of appropriate protective equipment and making vaccination readily available. Guidance recognizes that this responsibility may extend to requiring staff to be vaccinated (absent medical contraindication) when a safe, effective vaccine is available.

RECOMMENDATION

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

COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials
    a. vaccine is widely accessible;
    b. equity-centered privacy protections are in place to safeguard data collected from individuals;
    c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and

d. credentials address the situation of individuals for whom vaccine is medically contraindicated (New HOD Policy)

2. Recommends that decisions to mandate COVID-19 vaccination be made only:
   a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
   b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
   c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
   d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations. (New HOD Policy)

3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust. (New HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(JUN-21)

Introduced by: Maryland

Subject: Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication

Referred to: Reference Committee B

Whereas, Across the U.S., states passed telemedicine legislation in 2020 (pre-pandemic) that allows providers to use telehealth, including asynchronous technology, to establish the physician-patient relationship; and

Whereas, The ability to access health care via telemedicine prior to the pandemic was available, but not widely used; and

Whereas, Payments to physicians for telemedicine vary by carrier and were significantly less than in-person visits prior to COVID-19; and

Whereas, The onset and severity of COVID-19 caused a rapid implementation of telemedicine by physicians of many specialties, and patients rapidly embraced the technology as often the only means to access non-emergent medical care; and

Whereas, Through directives of the federal and state governments, payors waived co-pays and deductibles and increased payment for telemedicine and telephonic services equal to in-person visits during COVID-19 which reduced barriers for patients to access medical care; and

Whereas, The federal government and states took action to allow physicians and other health care clinicians to use non-HIPAA compliant platforms if necessary to enhance patients' use of technology to access health care; therefore be it

RESOLVED, That our American Medical Association address the importance of at least a 365-day waiting period after the COVID-19 public health crisis is over before commencement of audits aimed at discovering the use of non-HIPAA compliant modes and platforms of telemedicine by physicians. (Directive to Take Action)

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

Received: 04/07/21

AUTHOR'S STATEMENT OF PRIORITY

Due to urgent need, many physician practices implemented non-HIPAA-compliant telehealth platforms during the initial stages of the pandemic state of emergency in an attempt to ensure continuation of services and quality care for their patients. This resolution asks for the AMA to advocate for a 365-day waiting period after the COVID-19 pandemic crisis ends before commencement of HIPAA audits relating to telehealth usage. It is important that the AMA establish this policy platform before states of emergency expire and pandemic-related administrative flexibilities are terminated.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(JUN-21)

Introduced by: New York

Subject: Prohibit Ghost Guns

Referred to: Reference Committee B

Whereas, Homemade, difficult to trace firearms are increasingly turning up at crime scenes; and

Whereas, The most important part of a gun is the lower receiver - the 'chassis' of the weapon, the part housing vital components such as the hammer and trigger; and

Whereas, Under federal law, the lower receiver is considered a firearm - while other gun components do not require a background check for purchase; and

Whereas, Dozens of companies sell what are known as "80%" lower receivers - ones that are 80% finished, lack a serial number and can be used to make a homemade gun; and

Whereas, The Gun Control Act (1968) and the Brady Gun Violence Prevention Act (1993) allow for homemade weapons; and

Whereas, Ghost guns don't have any unique markings and therefore present black holes to police investigators; and

Whereas, Ghost guns provide an easy avenue for people banned from owning guns to obtain them; and

Whereas, According to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of all weapons recovered by the bureau in California were homemade; and

Whereas, These weapons have been connected with mass shootings, police shootouts and arms trafficking; therefore be it

RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/24/21

AUTHORS STATEMENT OF PRIORITY

This resolution expands the current AMA policy on gun safety. Additionally, it dovetails with the recently stated objectives of the US President and Senate Majority Leader. The best solution is a national (federal) one and AMA should be a part of that as a national organization. AMA must expand its policy to include this.

RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(JUN-21)

Introduced by: New York

Subject: Ban the Gay/Trans (LGBTQ+) Panic Defense

Referred to: Reference Committee B

Whereas, The gay/trans panic (to be more inclusive will use “LGBTQ+ panic”) defense strategy is a legal strategy that uses a victim’s sexual orientation or gender identity/expression as an excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent and lethal behavior (1); and

Whereas, The LGBTQ+ panic defense strategy gives defendants three options of defense: 1) insanity or diminished capacity, 2) provocation, 3) self-defense (3); and

Whereas, To claim:

- insanity, defendants claim that the sexual orientation or gender of the victim is enough to induce insanity (1);

- provocation, defendants claim “victim’s proposition, sometimes termed a “non-violent sexual advance” was sufficiently “provocative” to induce the defendant to kill the victim”(1);

- self-defense, “defendants claim they believed that the victim, because of their sexual orientation or gender identity/expression, was about to cause the defendant serious bodily harm (3)”; and

Whereas, Studies have shown that jurors with higher homonegativity and religious fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and

Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA recognized that no such condition exists; and

Whereas, Many murder sentences have been reduced or defendants have been acquitted using the LGBTQ+ panic defense strategy such as in the Matthew Shepard case, to successfully mitigate a charge from murder to criminally negligent manslaughter as recently as 2018 (1); and

Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation is the motivator of 17% of hate crime attacks with one in four transgender people becoming the victim of a hate crime in their lifetime (4, 5); and

Whereas, the LGBTQ+ panic defense has only been banned in 11 states as of February 2021, with legislation having been introduced in 12 more states (1, 2); and

Whereas, NY State passed a law in June 2019 banning the gay/trans (LGBTQ+) panic defense, and MSSNY should have policy to support this law and prevent the risk for a setback in protections for LGBTQ+ people; and

Whereas, At least 44 Transgender or Gender Non-Conforming persons have been killed in the US during the year 2020, the highest total since HRC started tracking in 2013 (9); and

Whereas, There is not a race panic defense for a reason, and similar reasoning must disallow a gay/trans (LGBTQ+) panic defense; therefore be it

RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called "gay/trans (LGBTQ+) panic" defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further

RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called "gay/trans (LGBTQ+) panic" defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called "gay/trans (LGBTQ+) panic" defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY:

Transgender people, our patients, specifically transgender women of color, are at an extremely high risk of dying by homicide. Last year a record number of deaths were recorded in the US (46- an underestimate given the under reporting of transgender identity). By mid-April, there are 15 known homicides of transgender people as reported by HRC. If this pace continues for 2021, another record will be broken on pace for over 50 homicides this year. AMA must act now to protect transgender people, and to send a clear message to all of our transgender patients and our LGBTQ+ patients, that we see them, value them, support them, and fight for them. This resolution must be heard at the AMA in June or another year of murders will occur before model legislation is shared, to provide justice for transgender people.

RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an

individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.
Citation: Res. 010, A-17

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(JUN-21)

Introduced by: New York

Subject: Insurers and Vertical Integration

Referred to: Reference Committee B

Whereas, Insurers already enjoy significant marketplace advantages, such as keeping healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony power; and

Whereas, These advantages have not resulted in cost savings (or even stability) for consumers--in fact cost increases born by consumers have been outsized and correlated with consolidation; and

Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting efficiency; and

Whereas, These "efficiencies" rarely, if ever, benefit the consumer; and

Whereas, These combined entities (especially vertical ones) are more competitive among their competitors than the uncombined ones (accelerating further consolidation); and

Whereas, The combined entities are also positioned (due to their superior access to capital) to unfairly disrupt entities at other points in the supply chain such as medical practices, community pharmacies, and safety net hospitals; therefore be it

RESOLVED, That our American Medical Association seek legislation and regulation to prevent health payers (except non-profit HMO's) from owning or operating other entities in the health care supply chain. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

As a matter of protecting public health and reducing health payor interference in patient care delivery, it is critical that AMA continue to actively work to prevent large entities from creating these monopolies. While the AMA has taken important steps in recent years to challenge these mergers and acquisitions, existing AMA policy is four years old. The efforts on the part of health payers to absorb practices, pharmacy benefit managers, medical equipment suppliers etc. continues and will create a health care market without any competition. This will not be good for our patients nor for physicians. These entities should be controlled by nothing more than the competitive free market system. Allowing health insurers to control more and more elements of the health care supply chain will result in even greater interference in the physician-patient relationship and decrease access to care for our patients. AMA is strongly urged to take immediate action to update its policy on this subject.

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920
Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.
Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(JUN-21)

Introduced by: South Carolina, Alabama, Florida, Mississippi, New Jersey, Oklahoma, West Virginia, Arkansas, North Carolina

Subject: Protection of Peer-Review Process

Referred to: Reference Committee B

Whereas, Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care; and

Whereas, It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care; and

Whereas, It is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care; and

Whereas, Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof; and

Whereas, The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself; and

Whereas, A U.S. Senate Oversight Committee in investigating UNOS (United Network for Organ Sharing) has subpoenaed “all relevant materials to include peer-review related materials”; therefore be it

RESOLVED, That our American Medical Association use its full ability and influence to oppose any new attempt(s) to make Peer Review proceedings, regardless of the venue, discoverable, even if by the US Congress or other US Governmental entity. (Directive to Take Action)

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

Received: 04/28/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered by our AMA House of Delegates as an URGENT resolution because of the on-going attempts by Oversight Committees of the US Congress to obtain peer-reviewed data which would include information by transplant surgeons as well as other physicians involved in the life-saving task of organ transplantation. There can be no guarantee that protected information would not be released in violation of the spirit of peer-reviewed procedures.

RELEVANT AMA POLICY

Legal Protections for Peer Review H-375.962

Definition and Purpose of Peer Review
Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.
Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.

Composition of the Peer Review Committee
Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.

Definitions

Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.

Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment

and intentional misconduct.

Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within his/her knowledge; but such witness cannot be asked about his/her testimony before a peer review organization or about opinions formed by him/her as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17

Reviewer Immunity D-375.997
Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law.
Citation: (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(JUN-21)

Introduced by: American Academy of Pediatrics

Subject: Redefining the Definition of Harm

Referred to: Reference Committee B

Whereas, Respecting and maintaining patients' confidentiality is imperative for the health and well-being of adolescent patients, the current HIPAA definitions only allow a physician to withhold the release of information in cases of anticipated *physical* harm to the patient or another individual; and

Whereas, The release of requested PHI on patients to their proxies and/or representatives in sensitive areas like reproductive health, mental health or substance use may not result in physical harm to the adolescent, it could result in severe mental anguish or emotional distress as they deal with the reaction from their family members and breach of privacy by their provider; and

Whereas, Pediatric patients, including adolescents, are unique in that their legal rights to provide consent and receive confidential care are limited, pediatricians and other clinicians who provide health care for children and adolescents, and who are stewards of EHI for those patients, should be granted discretion and latitude in sharing EHI when they are concerned about the impact/consequences for the child; and

Whereas, Adolescents by their nature often act impulsively, release of sensitive PHI that they do not want shared with others could result in mental or emotional harm that could lead to physical self-harm or an impulse to harm others; and

Whereas, Under current regulations (both HIPAA and the 21st Century Cures Act Interoperability Final Rule) physicians must release health information even when, in their professional judgement, they believe that doing so could emotionally or psychologically harm their patient; therefore be it

RESOLVED, That our American Medical Association advocate to the Office of Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the Office of Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health. (Directive to Take Action)

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

Received: 05/07/21

AUTHORS STATEMENT OF PRIORITY

The Federal Office of the National Coordinator for Health Information Technology allows physicians to block the release of medical information to patients and families that is “likely to endanger the life or physical safety of the individual or other person”, it currently excludes psychological or emotional harm, this resolution asks that that those harms be added as reasons a physician can choose to withhold or delay the release of medical information. Reducing harm to patients and families is an AMA priority, and the recently enacted medical information release rules will cause harm if psychological or emotional issues are not included in the definition of harm.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education

Referred to: Reference Committee B

Whereas, Advanced practice providers and allied health professionals are required under the laws of many states to be supervised to some degree by a physician; and

Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/gynecologists supervising social workers in the provision of group therapy[1] and plastic surgeons supervising physician assistants who advertise themselves as "dermatologists"[2]; and

Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers practicing in various fields while being nominally supervised by physicians not trained in those fields; and

Whereas, Physicians without appropriate training supervising advanced practice providers outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients; therefore be it

RESOLVED, That our American Medical Association conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in field which are not a core part of those physicians' completed residencies and fellowships. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $100,000.

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

As allied health providers have gained temporary independence and increased credit for their work during the pandemic, a proactive AMA attention and adequate data regarding supervision is needed to ensure that the supervision we are advocating for is indeed being provided and being done so for the specialty and procedures the physician is qualified to perform and oversee. The results of this study will be able to better inform our advocacy efforts and identify areas where our advocacy is not aligning with the standards we are holding ourselves to and will identify if we need to better regulate ourselves.

References:
1. Ornstein C and ProPublica. *Illinois leads Medicare billings for group therapy*. Chicago Tribune. 13 Jul 2014. https://www.chicagotribune.com/lifestyles/health/ct-medicare-group-therapy-met-20140713-story.html. Accessed 18 Sep 2019.
2. Al-agba N. *The P.A. Problem: Who You See and What You Get.* The Healthcare Blog. 24 Nov 2017. https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/. Accessed 18 Sep 2019.

RELEVANT AMA POLICY

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.
Citation: BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969
Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.
Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19

Physician Assistants and Nurse Practitioners H-160.947
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Regulation of Advanced Practice Nurses H-35.964
1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.
2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.
Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Health Workforce H-200.994
The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965
The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.
Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

Protecting Physician Led Health Care H-35.966
Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment. Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17;

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978
The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(JUN-21)

Introduced by: Pennsylvania

Subject: Increasing Residency Positions for Primary Care

Referred to: Reference Committee B

Whereas, We have many physicians (known to be in the thousands within the United States) that have completed the intense and specific education required in medical school whether at allopathic or osteopathic institutions and have successfully passed USMLE part 1, 2 CK and 2 CS or comparable examinations, but have not been able to obtain a residency due to the shortage of residency positions in the United States; along with a known shortage of physicians within the United States currently and presumed well into the future due to our aging population; and

Whereas, Even with the known shortage of physicians, and the increasing number of physicians without residencies expands as more and more candidates go unmatched due to the cap on Medicare support for graduate medical education residency positions are not increasing adequately to support the physicians that are available nor correcting the need for more practicing physicians; therefore be it

RESOLVED, That our American Medical Association prioritize the number of accredited residency positions, with the goal to increase the overall number especially in specialties deemed primary care (Directive to Take Action); and be it further

RESOLVED, That our AMA seek to increase the cap of Medicare support for graduate medical education. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

We view this to be a high priority rather than a top priority since it has a significant impact on a subset of physician, yet it has direct implication to physician shortage and thus effects patient care through altering scope of practice issues. Extended care providers champion manpower deficiencies in rural and economically challenged urban areas. This resolution that attempts to match the number of residencies with the number of certified candidates has benefits to patient care as a whole. Clearly as the resolution ask, we are requesting that the AMA continue to advocate for increased GME funding and to direct that funding particularly toward increases in what would be considered primary care residencies.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(JUN-21)

Introduced by: Pennsylvania

Subject: Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research

Referred to: Reference Committee B

Whereas, All-payer claims databases (APCDs) are centralized databases created to enable healthcare transparency and inform health policies at the state level; and

Whereas, APCDs are critical for emergent statewide research on topics including COVID-19; and

Whereas, APCDs often self-publishes high-level summaries of various aspects of the collected data in a format unsuitable for research; and

Whereas, APCDs deidentified dataset pricing structure is costly, curbing its use in academic research by students and scientists, thereby limiting utilization of this important data to assess novel questions; therefore be it

RESOLVED, That our American Medical Association advocate for affordable and open access to all all-payer claims databases (APCDs) data for academic research purposes. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

All-Payer Claims Databases, such as the PCH4 in Pennsylvania, allow for increased transparency of costs in the American healthcare system. Price transparency is a concept already supported by our AMA, but this resolution provides a specific example of existing raw datasets at the state level that are either inaccessible or too costly for effective utilization in academic research. We feel this is timely because, particularly in a time when health care may be experiencing a shift or even upheaval in the context of the current pandemic, academic researchers must have feasible access to the appropriate data to come to fair and effective conclusions regarding cost containment and proper use of healthcare resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(JUN-21)

Introduced by: Illinois

Subject: Ransomware and Electronic Health Records

Referred to: Reference Committee B

Whereas, Electronic health records are used as a repository of actionable medical records which is used by healthcare providers to provide optimal care to patients; and

Whereas, Access to electronic records in a timely fashion at the point of care can provide measurable and invaluable details about a patient's health history, including medications and allergies, medical and surgical history, family and social history, any of which could be used in treatment decisions which have measurable impact on the care provided and ultimately patient outcomes; and

Whereas, Ransomware is a form of malware that encrypts a victim's files. The attacker then demands a ransom from the victim to restore access to the data upon payment; and

Whereas, Ransomware can significantly interfere with the types and quality of care provided to patients by physicians and other health care entities, even to the degree of putting a patient's health and life at risk; therefore be it

RESOLVED, That our American Medical Association adopt policy acknowledging that healthcare data interruptions are especially harmful due to potential physical harm to patients and calling for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients (New HOD Policy); and be it further

RESOLVED, That our AMA seek to introduce federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents an issue that is timely and urgent.

Each and every day digital attacks occur in our health care delivery system. When a data breach occurs and system access is blocked it can be extremely harmful for patients.

Timely access to patient health care information and data is essential. Our current system for protecting patient EHR information from ransomware is not working. There need to be more severe penalties against perpetrators of malware and ransomware to deter future attacks and better protect patient information.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(JUN-21)

Introduced by: Illinois

Subject: Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

Referred to: Reference Committee B

Whereas, A topical stock-item medication is an unlabeled ointment or drop that the hospital operating room (OR), or Emergency Room (ER), or Ambulatory Surgical Treatment Center (ASTC) staff has on stand-by or is retrieved from a dispensing system for a specified patient for use during a procedure or visit; and

Whereas, Topical stock-item agents are charged to the patient, but unused medication often gets discarded when the patient is discharged, even if the medication is recommended for post-discharge care to aid in the patient's healing; and

Whereas, Because regulations governing the ability to dispense the remaining portion of stock-item medications for post-discharge use can be unclear or appear overly burdensome, many facilities do not allow the practice; and

Whereas, Patients may need to purchase duplicate agents for post-discharge use, increasing patient cost and creating medication waste; and

Whereas, Similar issues of cost inefficiencies and medical waste arise with the use of medications such as multiuse eye drops that are only allowed for single-patient use, but could safely be used in multiple patients; and

Whereas, The Joint Commission has previously approved specific policies and procedures implemented by the Utah Valley Regional Medical Center for the use of multi dose eye drops in multiple patients; therefore be it

RESOLVED, That our American Medical Association work with national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose eye drop bottles pre-operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution reflects an issue that is urgent. Health care costs have been rising at an unsustainable rate for years, jeopardizing patient access to care as costs escalate across all levels of the health care system. There is significant medical waste associated with the disposal of certain stock medications, which patients could continue to use safely if they were dispensed to the patient upon discharge. We should quickly pursue clarifying legislative and regulatory language that removes this barrier to the efficient and safe use of medications that would otherwise be wasted.

Reference:
Using multi dose eye drops in a health care setting: a policy and procedural approach to safe and effective treatment of patients. Jensen MK, et al. JAMA Ophthalmology 2014. https://jamanetwork.com/journals/jamaophthalmology/article-abstract/1901216

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(JUN-21)

Introduced by: American Academy of Dermatology, College of American Pathologists, Missouri, Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, Pennsylvania, Society for Investigative Dermatology, South Carolina, Iowa, American Society for Dermatologic Surgery

Subject: ONC's Information Blocking Regulations

Referred to: Reference Committee B

Whereas, On May 1, 2020, the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) published their separate but interrelated final rules implementing provisions of the 21st Century Cures Act (Cures) regarding interoperability, patient access to health data, data transparency electronic health information blocking and the ONC Health IT Certification; and

Whereas, These twin regulations aim to advance greater and widespread sharing of health information and transparency across the health care spectrum as well as promising to reduce administration burdens; and

Whereas, Both final rules are extensive and highly complex, impacting software technology developers, health information technology (HIT) vendors, payors, hospitals, medical practices, physicians, and certain provisions raise compliance concerns for physicians with respect to sharing, intervening and/or blocking patient's clinical information; and

Whereas, The ONC defines information blocking as "…a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of Health and Human Services (HHS) as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information (EHI);" and

Whereas, The ONC has established eight exceptions delineating activities that do not constitute information blocking, provided that certain conditions are met; and

Whereas, These ONC exceptions are intended to support and sustain "seamless and secure access, exchange, and use of electronic health information (EHI) and offer actors—health care providers, health IT developers, health information exchanges (HIEs) or networks (HINs)—certainty that practices that meet the conditions of an exception will not be considered information blocking;" and

Whereas, The ONC has classified eight exceptions in two categories—either involving not fulfilling requests to access, exchange, or use EHI or involving procedures for fulfilling requests to access, exchange, or use EHI; and

Whereas, The "Preventing Harm Exception" requires that physicians share a wide variety of medical information—including clinical progress notes, prescription medications and lab test

results—when readily available, in timely fashion and without delay, unless an exception to delay or withhold the release of the patient's information applies; and

Whereas, This requirement for immediate, automatic or "without delay" release of lab results to patients with or without the knowledge of the ordering physician strains and undermines the integrity of the physician-patients relationship and creates clinical workflow burdens and compliance challenges for certain medical specialties that rely on surgical pathology lab testing, results and inter-physician consultation with their pathologists; and

Whereas, Actors, including physicians, are afforded certain technical, compliance flexibilities under the information blocking provisions and its concomitant exceptions based on necessity, reasonableness, good faith efforts and professional clinical judgement within the scope and context of treating patients and preventing harm; and

Whereas, The ONC delayed the original compliance date for its information blocking provisions from November 2, 2020, to April 5, 2021, despite the AMA and other stakeholders urging a delay beyond the April 5, 2021 deadline; and

Whereas, Both deadlines still fall within the current COVID-19 public health emergency (PHE) that has caused uncertainties and challenges for the health care sector in general, with small and medium-sized medical practices facing ongoing, acute economic hardship; and

Whereas, § 4004 of the Cures Act authorizes and grants regulatory discretion to the Secretary of the Department of Health and Human Services (HHS) to identify reasonable and necessary activities that do not constitute information blocking; therefore be it

RESOLVED, That our American Medical Association advocate for additional time and compliance leeway for physicians by urging the Office of the National Coordinator for Health Information Technology (ONC) to broaden and relax their current regulatory requirements based on the following critical enumerated requests:

a. Urge the ONC to strike the right balance between the demands and distress caused by the COVID-19 public health emergency (PHE) and its interoperability rule objectives.
b. Urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.
c. Urge the ONC, through an interim final rule moratorium, to delay the current applicability date of information blocking provisions until 12 months after the PHE is officially declared over, affording small and medium-sized medical practices time to recover and prepare.
d. Urge the Department of Health and Human Services (HHS)'s ONC and their OIG to propose future enforcement discretion that would afford small and medium-sized medical practices further compliance flexibilities given their lack of resources.
e. Call on the HHS's ONC and OIG in future enforcement rulemaking to propose corrective action and further technical guidance rather than imposing fines or penalties.
f. Urge the ONC to broaden and relax its Patient Harm Exception through subregulatory revisions that would include patients' emotional and mental distress to the current and narrow definition of this exception.
g. Call on the ONC to develop and offer more meaningful educational guidance, practical resources, and technical assistance to physician practices to help them meet their compliance efforts, patient care obligations and documentation requirements. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Prioritization for J21 is sought in order to immediately request delay for compliance and clarification for information blocking provisions in the recently implemented 21st Century Cures Act. Practices are struggling to invest in the technology for immediate release of all medical information (e.g. notes, prescriptions, and lab tests, etc.) at the time of financial strain caused by the current COVID-19 public health emergency. The pandemic has put undue financial burden on physician practices, especially small practices. Unanticipated investment in information technology was required to quickly transition to telehealth services. Right now, it's an unreasonable time for practices to spend even more for information technology services to comply with information blocking regulations. Many practices, especially primary care practices, are operating with inadequate margins. A survey by the Physicians Foundation estimated that 8 percent of all physician practices nationally — around 16,000 — have closed under the stress of the pandemic. Advocating for an extension for compliance is timely so that practices can first get on their feet, recoup financial losses and then incorporate recommended changes.

RELEVANT AMA POLICY

EHR Interoperability D-478.972
Our AMA:
(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
(4) will continue efforts to promote interoperability of EHRs and clinical registries;
(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
Citation: Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep.

45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20;

Health Information Technology Principles H-478.981
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physicians ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.
Citation: BOT Rep. 19, A-18; Reaffirmation: A-19

1.1.1 Patient-Physician Relationships
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include: (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit. (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment. (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists. AMA Principles of Medical Ethics: I,II,IV,VIII Issued: 2016
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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(JUN-21)

Introduced by: Association for Clinical Oncology, American Academy of Ophthalmology, American College of Rheumatology

Subject: CMMI Payment Reform Models

Referred to: Reference Committee B

Whereas, The 2020 Medicare Trustees Report projects that the Part A trust fund will become insolvent in 2026; and

Whereas, Physicians in communities across the country and medical specialty societies are developing innovative ways to reduce costs; and

Whereas, Cost-containment strategies should not limit the ability for patients to receive access to appropriate care, or for providers to prescribe such care; and

Whereas, New approaches for care delivery and reimbursement should be tested through multiple, voluntary demonstration projects to yield insights about the impact of the policy changes and allow for public comment prior to broader implementation; and

Whereas, Different specialties' processes of care are as diverse as the range of problems they address, such that a payment system that works well for one specialty would not fit another specialty; and

Whereas, Communities have different cultures, economics, and levels of social support and therefore a payment solution that works well in one community may not work well in another community; and

Whereas, The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has reviewed and assessed physician-focused payment models (PFPMs) based on stakeholder proposals submitted to the committee, but the Center for Medicare and Medicaid Innovation (CMMI) has not acted on their recommendations; and

Whereas, The Medicare Payment Advisory Commission (MedPAC) released a report in April 2021 recommending fewer models be offered by CMMI; and

Whereas, A new Administration creates opportunities to develop and test new models that incentivize--not hamper--innovation that results in clinically meaningful improvements in patient outcomes; therefore be it

RESOLVED, That our American Medical Association continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our AMA's current policy on Medicare demonstration projects focuses on including physicians and specialty societies in the development process of alternative payment models; however, it doesn't go far enough to make recommendations on the scale and scope of potential projects.

In recent months the Biden Administration has been pausing several prominent value-based reimbursement models run by CMS Innovation Center (CMMI) that had been approved and implemented by the Trump Administration in order to review model details. This intense audit of the previous administration's demonstration projects, coupled with the Medicare Payment Advisory Commission (MedPAC)'s April 2021 report recommending CMMI offer fewer models in the coming years, indicates that the new administration will likely put any newly proposed models through a longer and more rigorous review process prior to implementation. This provides a clear opportunity for our AMA to play an even more targeted role in shaping the proposals that will be considered.

If our AMA can seize on this opportunity to recommend that CMMI's newly proposed models focus on the development of multiple localized pilot projects across many specialties, we can help shape demonstration projects that physicians are incentivized to join voluntarily and that meet the needs of the communities they serve. This approach will be a benefit to care delivery across specialties and it is timely considering how early we still are in the new administration.

Above and beyond that, we need to begin the process now so that this new policy can be incorporated into our advocacy strategy. Given the timeliness and the low volume of projects that will be considered during the current administration, it is urgent that our AMA take up this resolution to ensure that future CMMI projects are voluntary and tailored to the needs of the specialized local communities that they serve.

The negative repercussions of demonstration projects that do not meet these requirements are likely long lasting and difficult to reverse.

[1] https://fas.org/sgp/crs/misc/RS20946.pdf

RELEVANT AMA POLICY

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908
1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.

3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
a. Continue to expand technical assistance
b. Develop IT systems that support and streamline clinical participation
c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided
d. Identify methods to reduce the data collection burden; and
e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patients health and success of treatment, such as disease stage and socio-demographic factors
b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
c. Explore an approach in which the physician managing a patients care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode
b. Distinguish between services ordered by a physician and those delivered by a physician
c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care
d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patients and physicians responsibility for managing the condition; and
e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending
b. Account for costs that are not currently billable but that cost the practice to provide; and
c. Account for lost revenue for providing fewer or less expensive services.
Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20

Medicare Demonstration Projects D-330.948
Our AMA will: (1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care; (2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects; (3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and (4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians.
Citation: (CMS Rep. 3, A-05; Reaffirmed: CMS Rep. 1, A-15)

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
Citation: Res. 241, A-16;

Medicare Physician Payment Reform D-390.961
1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16;

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
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Res. 241, A-16

Medicare Physician Payment Reform D-390.961
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6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(JUN-21)

Introduced by: Medical Student Section

Subject: Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities

Referred to: Reference Committee B

Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million undocumented immigrants were living the United States[1]; and

Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48 immigration policy changes that have not only affected international travel, student visas, and immigration, and asylum processes, but also caused significant confusion for immigration lawyers[2-4]; and

Whereas, The suspension of the United States Custom and Immigration Services (USCIS) during the COVID-19 pandemic has led to a back-up in the processing of necessary documentation, which has left many unable to access certain benefits necessary for work, receiving healthcare, and accessing public benefits[5]; and

Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-detained individuals on March 18, 2020, which delayed the processing of asylum seekers enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary conditions that promotes the spread of the virus[5]; and

Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both entry at the northern and southern borders and barred asylum seekers from entering the country due to public health threats, despite evidence suggesting that such restrictions are ineffective and may even divert resources from other interventions[5]; and

Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed hearings for detained people, prolonging their stay in detention centers[4,5]; and

Whereas, The relief packages that were provided by the government during the pandemic either provided little or no coverage to immigrants and their families, leaving them with few options for testing and treatment[5,7]; and

Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19 related services available under emergency Medicaid, which means that immigrants are unable to access these services since they cannot apply for non-emergency Medicaid due to immigration eligibility criteria[1,5,8]; and

Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive unemployment insurance or government stimulus checks during national crises[5,9]; and

Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to receive a stimulus payment to individuals with a social security number, which limits many immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)[1,5,8]; and

Whereas, Lapses in work authorization due to slowed processing times and suspension of required processing services may result in immigrants being unemployed or losing benefits offered by their employer[5,8]; and

Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI) programs, but due to lapses in work authorizations, many immigrants may either not qualify or lose access to this vital benefit[1]; and

Whereas, Previous immigration law changes, such as the February 2020 Public Charge rule, penalized immigrants for using non-cash public assistance like Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the Children's Health Insurance Program (CHIP), several housing programs, and federal poverty level determination by threatening inadmissibility or inability to be granted legal permanent residency in the United States[10,11]; and

Whereas, These changes not only discourage use of publicly funded healthcare and welfare services even among immigrant families to which the rule does not technically apply due to fear and confusion, but also mislead countless immigrant parents to remove their U.S. citizen children from health care insurance, likely leading to unnecessary child morbidity and mortality[10,12-15]; and

Whereas, Decreased participation in public benefit programs would contribute to a greater uninsured population, a decrease in the use of both preventive and curative health services, and negatively affect the health outcomes and financial stability of nearly 22 million noncitizens currently residing in the U.S.[10,16,17]; and

Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the COVID-19 pandemic would not count as a public charge[18,19]; and

Whereas, Although two filed lawsuits have prevented this ruling from being enacted further, there remains a concern on the potential for future immigration policy to discriminate based on poverty level, housing status, and the need for public benefits[17-19]; and

Whereas, Increased fear of deportation among families, even if only one family member is a non-citizen immigrant, not only causes decreased health care utilization but also causes increased behavioral issues in children[17]; and

Whereas, The 3rd AMA Principle of Medical Ethics states, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient" [10]; and

Whereas, Our AMA is opposed to any proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP (AMA Policy D-440.927); and

Whereas, Our AMA joined other health care organizations in submission of amicus briefs and comment letters opposing the new public charge regulations, stating "there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment

or educational status of immigrants. These sweeping and detrimental changes will ultimately result in far greater costs to the public's health than any purported benefit offered by DHS" [11]; and

Whereas, Our AMA has set policy precedent to act on behalf of the health of immigrants, refugees, migrant workers, and asylum seekers (AMA Policy H-350.957), and has joined other health care organizations in submitting amicus briefs and comment letters opposing the new public charge regulations, stating "there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment or educational status of immigrants... These sweeping and detrimental changes will ultimately result in far greater costs to the public's health than any purported benefit offered by DHS"[11]; therefore be it

RESOLVED, That our American Medical Association, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:

(1) oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; and
(2) oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and
(3) support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and
(4) oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-350.957, "Addressing Immigrant Health Disparities," by addition to read as follows:

Addressing Immigrant <u>and Refugee</u> Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of <u>immigrants and</u> refugees and encourages the exploration of issues related to <u>immigrant and</u> refugee health and supports legislation and policies that address the unique health needs of <u>immigrants and</u> refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

<u>4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status.</u> (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The recent proposal and implementation of actions like asylum seeker bans, refugee entry suspensions, and postponing of Migration Protection Protocol hearings clearly demonstrate the need for a strong stance on immigrant protections during states of national emergency. Our delegation considers immigrant health and protections to be our strongest priority and ranked this resolution accordingly. To ensure our asks are actionable, the language of our resolution was crafted with the assistance of AMA advocacy staff.

This resolution strengthens AMA policy on legal immigrants' right to health care. It also broadens current policy so the AMA can continue to engage in conversations on immigration policy and their impact on immigrant health. The AAP has released several policy statements on the treatment of immigrant and refugee children, especially as it pertains to the use of detention centers and family separation policies, demonstrating that it is appropriate for our AMA to update existing policies on these issues.

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18
HIV, Immigration, and Travel Restrictions H-20.901
Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(JUN-21)

Introduced by: Medical Student Section

Subject: Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs

Referred to: Reference Committee B

Whereas, Public assistance programs provide financial assistance to low-income individuals and families to prevent falling below the poverty line due to costs of living, health care, and food[1]; and

Whereas, One in five Americans receives benefits from at least one public assistance program[1]; and

Whereas, Public assistance programs, like the Supplemental Nutrition Assistance Program (SNAP), commonly known as "food stamps," and the Temporary Assistance for Needy Families (TANF), commonly known as "welfare," provide financial assistance to low-income individuals and families to address domestic hunger and similar basic needs[2-3]; and

Whereas, SNAP and TANF are partnerships where federal and state governments share administrative responsibilities and expenses for beneficiaries[2,3]; and

Whereas, SNAP usage is associated with improved nutrition, lower cost of health care among recipients, and reduced risk for several chronic medical conditions including coronary artery disease, cancer, asthma, and diabetes[4]; and

Whereas, Resource limitations and stringent requirements, such as federal law which requires all TANF recipients work for a minimum of 30 hours per week or 20 hours per week for single parents with children under the age of 6 years, prevent TANF from benefiting many low-income families[3,6]; and

Whereas, In order for individuals to qualify for SNAP, federal law requires work or participation in employment and training programs for certain adults aged 18 to 59[5]; and

Whereas, Efforts to increase work requirements for recipients of public assistance programs can have negative effects on recipients' health outcomes and limit their ability to find stable employment[6-7]; and

Whereas, Many recipients register for public assistance programs only after losing employment, and more than 80 percent report securing employment within a year after starting to receive SNAP benefits[6-7]; and

Whereas, Increased work requirements to qualify for public assistance programs create administrative barriers that prevent even working recipients from receiving benefits, and have the potential to restrict coverage for those with chronic medical conditions, including mental illness and substance abuse disorders[6-8, 17]; and

Whereas, Increased work requirements to qualify for public assistance programs are not shown to improve health outcomes or reduce employment barriers[6,9]; and

Whereas, Both federal and state governments share authority over work requirements for public assistance programs, and states can exempt recipients from federal work requirements at their discretion to allow more individuals to benefit from public assistance programs[2,5,10]; and

Whereas, Our AMA opposes work requirements for the public assistance program Medicaid[11]; and

Whereas, In a 2018 letter to the US Senate, our AMA expressed support for the preservation of SNAP and opposed proposed increases in work requirements that would reduce benefits for recipients[12]; and

Whereas, While AMA undertook this action, existing policy on SNAP is vague, stating that "Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives" and does not explicitly describe our opposition to increasing work requirements[13]; and

Whereas, In 2019, the US Department of Agriculture considered new regulations that would remove SNAP benefits from hundreds of thousands of recipients, by preventing states from (1) exempting recipients from SNAP work requirements, (2) expanding SNAP eligibility standards beyond the federal minimum, and (3) automatically qualifying individuals for SNAP based on TANF eligibility, all of which are efforts taken by states to expand benefits to more low-income individuals[14-16]; therefore be it

RESOLVED, That our American Medical Association support reduction and elimination of work requirements applied to the Supplemental Nutrition Assistance Program and the Temporary Assistance for Needy Families Program (New HOD Policy); and be it further

RESOLVED, That our AMA support states' ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections of a social safety net for marginalized populations, including those of low socioeconomic status and who require public assistance. This resolution asks the AMA to support exemptions to work requirements and eligibility expansions in public assistance programs.

Our AMA already has policy opposing Medicaid work requirements, but does not have formal policy regarding work requirements for SNAP or other social support programs such as TANF. These programs already contain federally mandated work requirements, but states have traditionally been able to exempt beneficiaries from these requirements. States have also traditionally auto-qualified beneficiaries for SNAP based on their eligibility for TANF services to enroll individuals more easily in public assistance programs. Given prior attempts by the federal government to prevent states from taking these important actions, it is important to make an evidence-based AMA policy that supports work requirements exemptions for beneficiaries and easier access to public assistance programs.

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RELEVANT AMA POLICY

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility. (Res. 802, I-17; Reaffirmation: A-18)

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
(Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18)

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
Our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children’s Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include

additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, AMA-MSS Digest of Policy Actions/ 190 congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children’s Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

(BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(JUN-21)

Introduced by: Medical Student Section

Subject: Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies

Referred to: Reference Committee B

Whereas, Under current federal law, any individual convicted of a drug-related felony is not eligible for benefits under the Supplemental Nutrition Assistance Program (SNAP)[1]; and

Whereas, This provision was originally part of a much larger welfare-reform package passed in 1996 to deter individuals from drug-related crimes and decrease misuse of the welfare system[4]; and

Whereas, As of March 2019, only 3 states and territories currently maintain this lifetime ban, 24 states have modified this ban on SNAP for persons convicted of a drug-related felony, and 25 states have repealed this ban altogether[2,3]; and

Whereas, Many state-based modifications to this ban entail limiting the classes of drug felonies subject to restriction, creating short-term bans, requiring drug-testing for enrollees, and requiring enrollment and participation in drug treatment programs[5]; and

Whereas, Based on a regression discontinuity analysis performed with data comparing recidivism in convicted drug traffickers in Florida immediately before and after the institution of the federal SNAP ban, banning access to SNAP has been associated with an increased likelihood of criminal recidivism[6]; and

Whereas, An economic study examining administrative data on released offenders in 43 states has found that eligibility for SNAP and Temporary Assistance for Needy Families (TANF) “at the time of release from prison significantly reduces the risk of returning to prison within one year by up to 10%”[7]; and

Whereas, Food insecurity is defined by the condition of households that, at times, were “unable to acquire adequate food for one or more household members because they had insufficient money and other resources for food”[8]; and

Whereas, 11.1% of American households reported experiencing food insecurity at least at some point during 2018, while a pilot study with a sample size of 110 former drug offenders indicated a food insecurity prevalence of 91%[5, 9, 10]; and

Whereas, Food insecurity is associated with higher risk of chronic disease, including diabetes, obesity, depression, and hypertension[11,12]; and

Whereas, Access to SNAP benefits has been associated with improved health as indicated subjectively by higher ratings of self-assessed health, with significantly increased probability of

reporting excellent or very good health, and objectively by fewer days in bed due to illness[10]; and

Whereas, Evidence suggests that although SNAP participants have fewer office-based medical visits overall, , they have more preventative checkups and fewer diagnostic or emergency visits than non-participants[13]; and

Whereas, Existing AMA policy (H-270.966) opposes requiring SNAP applicants or beneficiaries to disclose medical information, including former drug use and treatment history, and opposes denying assistance from these programs based on substance use status, and also supports the preservation of SNAP to increase access to healthful foods and decrease food insecurity (H-150.937); and

Whereas, Current AMA policy does not address the impact of current federal law regarding criminal drug offenses and subsequent access to SNAP benefits; therefore be it

RESOLVED, That our American Medical Association oppose any lifetime ban on SNAP benefits imposed on individuals convicted of drug-related felonies. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections of a social safety net for marginalized populations, including those of low socioeconomic status and who require public assistance. This resolution asks the AMA to oppose any federal lifelong ban on SNAP benefits for persons convicted of drug-related felonies given the potential for serious negative health and social consequences.

This resolution addresses a gap in AMA policy, and details why these individuals should not be restricted from accessing SNAP benefits once their sentence is concluded. SNAP is a program providing nutritional assistance to people who cannot afford it, and currently only persons convicted of drug-related felonies are subject to this federal ban--those convicted of murder, theft or other felonies can still get access to SNAP. Given that our AMA already supports SNAP, this policy is in-line with our belief that SNAP should be accessible to reduce food insecurity.

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RELEVANT AMA POLICY

Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966

Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status. (Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07; Modified: Res 203, A-16)

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. (Res. 414, A-10; Reaffirmation, A-12; Reaffirmation, A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation, A-14; Reaffirmation, I-14; Reaffirmation, A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(JUN-21)

Introduced by: Medical Student Section

Subject: Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19

Referred to: Reference Committee B

Whereas, The USDA Food and Nutrition Service (FNS) administers 15 federal nutrition-assistance programs across the country[1]; and

Whereas, The National School Lunch Program (NSLP) and the School Breakfast Program (SBP), provide vital sources of food for low-income children during the school year[1]; and

Whereas, In the 2018-19 school year, the NSLP, which had a $12.5 billion budget in 2016, served 4.9 billion lunches to 29.6 million children around the country, and the SBP served 2.5 billion breakfasts to 14.8 million children[1,2]; and

Whereas, The U.S. Department of Agriculture (USDA) National School Lunch Program, School Breakfast Program, and Child and Adult Care Food Program serve nearly 35 million children daily[3]; and

Whereas, Children living with families whose incomes are at or below 130 percent of the federal poverty level (currently $26,200 for a family of four) are eligible for free meals, and those with incomes between 130 and 185 percent of the federal poverty level are eligible for reduced-price meals[1,2]; and

Whereas, Children automatically qualify for free meals if their household participates in the Supplemental Nutrition Assistance Program (SNAP), and they may be matched through other programs, such as the Temporary Assistance for Needy Families cash assistance program or the Food Distribution Program on Indian Reservations[1]; and

Whereas, Schools and school districts that have at least 40 percent of students deemed automatically eligible for free lunch may participate in the Community Eligibility Provision (CEP), which allows schools to serve universal free meals without collecting household applications[1]; and

Whereas, CEP allowed more than 13.6 million students in more than 28,000 schools to receive free lunch in the 2018–19 school year[1]; and

Whereas, Based on an online survey (n=584), pick-up school-provided meals during the pandemic were received by 40.0% of families, while 27.8% received SNAP benefits, 11.7% received WIC benefits, and 16.5% received meals from local food banks or food assistance programs[4]; and

Whereas, The COVID-19 pandemic contributed to a 17% overall decrease in the percentage of food secure families, while the overall percentage of families experiencing very low food security increased by 20%[4]; and

Whereas, Food insecurity is negatively associated with health outcomes, including poor mental health outcomes such as depression, stress, and anxiety, poor diet quality, high rates of chronic diseases such as diabetes and obesity, and a lower overall health status[5]; and

Whereas, The COVID-19 pandemic, and the associated social and economic responses have the potential to dramatically increase food insecurity and its related health disparities among already at-risk populations[5]; and

Whereas, Studies have shown that the United States' food system is not resilient against the expected level of worker unemployment during a pandemic. With the unprecedented rise in U.S. unemployment rate, and the fact that rates of food insecurity parallels unemployment and economic trends, food insecurity is predicted to climb higher as the pandemic progresses[5,6]; and

Whereas, Around 60.1% of families experienced a decrease in income during the pandemic, 23.4% of which were low food secure and 42.5% were very low food secure[4]; and

Whereas, Families that were already experiencing food insecurity before COVID-19 are more likely to have worsened insecurity during the pandemic, specifically 46.5% of these families experienced very low food security during this time[4]; and

Whereas, Individuals with low or very low food security are more likely to be non-Hispanic Black or Hispanic, be of lower socioeconomic status, have children in the home, not have health insurance or have Medicaid, and are more likely to be receiving SNAP benefits[7]; and

Whereas, This racial disparity in food security status is yet another example in which COVID-19 is disproportionately impacting minority and other marginalized communities in the United States[7]; and

Whereas, In comparison with 8% of white students, 45% of African American and Hispanic children attended high-poverty schools, where ≥75% of the student population have free or reduced-price lunch eligibility[8]; and

Whereas, Some solutions that have been enacted in order to provide meals for students that are not physically attending school have included waivers for school districts, such as allowing schools to serve meals outside of their standard times, that allow for expansion of normal meal assistance programs[1]; and

Whereas, The increased need for meals and short time constraint of the pandemic have led to decreased reimbursement rates per meal, which only exacerbates the increased cost of these programs caused by staffing and delivery difficulties[1]; and

Whereas, Some school districts offer the Summer Food Service Program (SFSP) and the Seamless Summer Option (SSO), which are typically used to continue serving meals to children during unanticipated school closures[1]; and

Whereas, Despite various efforts to provide access to meals for families and children not at school, only 11% of newly unemployed families were reporting access to "grab-and-go" meals during the pandemic[9]; and

Whereas, The Pandemic Electronic Benefit Transfer (P-EBT) program was reauthorized in the Families First Coronavirus Act, and enables states to enact emergency standards of eligibility for children who have lost access to free- or reduced-price meals because their schools closed for at least five consecutive days in response to the COVID-19 pandemic[1]; and

Whereas, The P-EBT program provides households for whom schools are closed for 20 days in a month a total benefit of $115.60 per child[1]; and

Whereas, Certain restrictions that exist for those using federal meal benefits, such as purchasing restrictions, may lead to decreased ability to purchase certain types of food or purchase food through some means[10]; and

Whereas, Available programs and offerings that the federal government have put in place have not been widely or equally adopted by states, leading to exacerbation of disparities on a geographical basis[10]; and

Whereas, Shifting the main responsibility of providing nutrition to children to the SNAP program may have negative health implications, since SNAP does not adhere to strict nutrition guidelines in the same ways that school meal programs must[3]; and

Whereas, There has not been a mandate released by the USDA to offer food service during school closures or for students who are not physically present at schools[3]; and

Whereas, The United States Food and Nutrition Service (FNS) released a statement that reaffirmed their commitment to allowing states to serve free meals to children, launching Pandemic-EBT (P-EBT), increasing SNAP benefits, addressing supply challenges, providing billions of dollars in food through local food banks, food pantries, and disaster household distributions, and approving nearly 3,000 flexibilities and program adjustments to ease operations and protect the health of applicants and participants[11]; and

Whereas, Previous AMA policies established precedent for the AMA's support of healthy meals and the availability of nutrition through school lunch programs for children (AMA Policies H-150.962 and H-150.937); therefore be it

RESOLVED, That our American Medical Association amend policy H-150.962, "Quality of School Lunch Program," by addition as follows:

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
3. Our AMA support adoption and funding of alternative nutrition and meal assistance programs during a national crisis, such as a pandemic. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections for a social safety net, and this resolution addresses the issue of food insecurity for children during national emergencies. This resolution seeks to amend existing AMA policy H-150.962 to better address a gap in policy and allows our AMA to advocate for increased nutritional assistance programs.

The COVID-19 pandemic has certainly highlighted systemic inequalities, including food insecurity. Particularly in children, food insecurity has been shown to have adverse health and behavioral outcomes. The United States has seen an increase in food insecurity of almost 30% in households with children, a significant portion of which disproportionately impacts children of color, further contributing to the burden of disparities faced during this pandemic by communities of color. In a time such as a pandemic, when state and federal level nutrition and meal assistance programs are in high demand, the asks for increased funding and further advocacy supporting the adoption of these programs is warranted.

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RELEVANT AMA POLICY

Quality of School Lunch Program H-150.962
1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.
Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.
Res. 921, I-18

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.
Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(JUN-21)

Introduced by: Medical Student Section

Subject: Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity

Referred to: Reference Committee B

Whereas, The United States government manages the largest immigration detention system in the world[1]; and

Whereas, The U.S. Customs and Border Patrol (CBP) and U.S. Immigration and Customs Enforcement (ICE), both under the jurisdiction of the Department of Homeland Security (DHS), are meant primarily to process non-US citizens (immigrants, migrants, and asylum seekers) and the intention of their detention centers is to temporarily hold people until their cases are heard or they are deported[2,3]; and

Whereas, For ICE detention facilities, a 2019 report by DHS Office of the Inspector General found 14,000 health and safety deficiencies mainly related to physical and mental health care procedures for detainees[4]; and

Whereas, 23 deaths (42% of deaths) occurred due to substandard care in ICE immigrant detention centers between 2010 and 2018[5]; and

Whereas, For CBP detention facilities, a 2019 report by DHS Office of Inspector General showed that prolonged detention in overcrowded CBP facilities has resulted in unhealthy living conditions, including sparse bathing and cleaning supplies, which has been confirmed by attorneys of the detainees[6,7]; and

Whereas, Increased duration of detention is associated with increased symptom severity with respect to mental health conditions including post-traumatic stress disorder and depression[8]; and

Whereas, No empirical evidence supports the assumption that the threat of being detained deters irregular migration[9]; and

Whereas, Policy organizations across the political spectrum agree that there are viable alternatives to immigrant detention centers overseen by the Department of Homeland Security (DHS)[10-12]; and

Whereas, Alternatives to Detention (ATD) programs include the Intensive Supervision Appearance Program, Bonds, Family Case Management Program, and Community Management Programs, which include one or more of caseworker assignments, home check-ins, ICE check-ins, and/or telephonic monitoring[10,11,13,14]; and

Whereas, International program data on ATDs demonstrate improved health outcomes, decreased costs, increased compliance with immigration check-ins and hearings, and preserved family unity compared to detainment[9,14,15]; and

Whereas, The United States Government Accountability Office reported that the daily cost of ATDs is less than 7% of that of detention centers, thus ATDs cost less than seven cents for every dollar required to operate detention centers[15]; and

Whereas, The FCMP also demonstrated that ATD programs could be more economic than detention centers, costing approximately $38.47 per family per day as compared to $237.60 per family per day[16]; and

Whereas, 99% of the 630 asylum seekers who participated in the Family Case Management Program (FCMP), an ICE-run ATD program, complied with ICE monitoring requirements[16]; and

Whereas, Previously implemented ATD programs such as the Community Support Initiative and the Appearance Assistance Program showed similarly high rates of compliance to FMCP[12,17]; and

Whereas, The American Academy of Pediatrics, the American College of Physicians, and Doctors for Camp Closure have recommended the use of ATD programs for immigrants, and particularly for children[18,19]; and

Whereas, ATD programs would achieve the healthcare quality goals of AMA policy D-350.983 for improving medical care in immigrant detention centers, and better align with our policy H-65.965 on human dignity and human rights; and

Whereas, The term ATD is broadly defined and inclusive of alternatives that could be considered exploitative or inhumane, such as applying high bail bonds or excessive surveillance, thus creating a need to distinguish between ATD programs that respect human dignity and those that do not[10]; and

Whereas, Our AMA supports “the dignity of the individual, human rights and the sanctity of human life,” (H-65.965); therefore be it

RESOLVED, That our American Medical Association advocate for the preferential use of Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The U.S. government manages the largest immigration detention system in the world, which is meant to temporarily hold non-US immigrants, migrants, and asylum seekers until their case is heard or until deportation. Alternatives to Detention Centers are defined, established programs that respect human dignity in a way that current detention centers do not by virtue of not placing undocumented immigrants in what amounts to jail cells and isolation from family and loved ones.

This resolution asks our AMA to support humane alternatives to detention centers, such as Intensive Supervision Appearance Program, Bonds, Family Case Management Program, and Community Management Programs. We request that the House of Delegates consider this resolution in light of COVID-19 and unsafe hygienic conditions that detainees are made to live in. Detention centers are ripe environments for spread of COVID-19 and other communicable diseases given crowding and poor hygiene.

Our delegation considers this resolution a priority due to the ongoing nature of this problem: if Our AMA HoD does not address this issue urgently, additional children will be taken from their mothers, additional families and additional detainees will suffer or die from unhygienic conditions. These alternative to detention programs are feasible, cheaper than current detention methods, more humane, and will not have the extensive negative impact on physical and mental health of immigrants and asylum seekers that detention does.

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RELEVANT AMA POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigration and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
Res. 017, A-17

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
Res. 002, A-17

Opposing the Detention of Migrant Children H-60.906

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(JUN-21)

Introduced by: Medical Student Section

Subject: Oppose Tracking of People who Purchase Naloxone

Referred to: Reference Committee B

Whereas, The number of opioid deaths has been steadily increasing over the past two decades; approximately 130 Americans die each day from opioid overdose[1]; and

Whereas, Naloxone hydrochloride is a competitive antagonist against the mu-opioid receptor that can be used to counteract the effects of opioids to reverse an overdose[2,3]; and

Whereas, Due to the rising prevalence of opioid use disorder (OUD), the FDA approved the use of naloxone products by bystanders who suspect opioid overdose[4]; and

Whereas, Naloxone has an established history of safe and effective use to combat opioid overdoses and has no abuse potential[5,6]; and

Whereas, Naloxone has few adverse effects and is very effective at reversing the actions of opioids[7]; and

Whereas, When naloxone is given to healthy volunteers with no recent opioid exposure, naloxone has no clinical effect, but when given to someone who is unresponsive for a reason other than opioid toxicity, naloxone is unlikely to cause harm[7,8]; and

Whereas, A prospective, randomized trial showed that intramuscularly or intranasally administered naloxone showed low rates of minor adverse events (e.g. headache, nausea, irritation) and major events (e.g. seizure) were not found[6]; and

Whereas, A systematic review on the management of opioid overdose with Naloxone reports low rates of death or adverse outcomes (0% to 1.25%) for patients who were administered naloxone and not brought to a healthcare facility[9]; and

Whereas, The World Health Organization (WHO) has recommended the widespread availability of naloxone to counteract opioid related deaths[10]; and

Whereas, Take-home naloxone programs are effective for reducing opioid-overdose mortality, and the efficacy of reversal by laypersons is 75-100%[4,8]; and

Whereas, Between 1996 and 2014, 644 local sites in 30 states and the District of Columbia distributed 152,000 naloxone kits and reported 26,000 successful drug overdose reversals[11]; and

Whereas, As of July 2017, all 50 states and the District of Columbia have passed laws that increase public access to naloxone and 43 states have issued standing orders allowing non-medical persons to obtain and administer naloxone[12,13]; and

Whereas, Reviews have found that expanding the supply of naloxone is not associated with compensatory drug use or greater risk-taking[14,15]; and

Whereas, Many people who purchase and use naloxone are friends, family, and community members who are not at risk of opioid overdose themselves, which means that the purchase of naloxone is not indicative of overdose risk[16–18]; and

Whereas, Federal law (42 Code of Federal Regulations, Part 2) protects patient confidentiality as it pertains to substance use treatment and does not require this information be placed in the electronic medical record[19]; and

Whereas, Naloxone purchased without a prescription will be recorded at the pharmacy of purchase[20]; and

Whereas, The state of Nebraska maintains a prescription drug monitoring program, which will track all dispensed prescriptions in the state including those for naloxone[24]; and

Whereas, In Massachusetts, a state with a standing order allowing healthcare workers to purchase naloxone, more than a half dozen employees at Boston Medical Center were denied life and disability insurance due to receipt of naloxone; this is a problem that has occurred in multiple states[25,26]; and

Whereas, The presence of any evidence of substance use treatment including naloxone purchases on a medical or insurance record may bias the provider and result in alteration of the care provided[21–23]; and

Whereas, Physicians who believe their patients have an OUD are less likely to provide them with appropriate pain management and are more likely to assume symptoms are due to their OUD[27]; and

Whereas, There is no data to support that tracking naloxone purchase history provides any health benefits, but it may reduce people's willingness to purchase naloxone[25,28]; and

Whereas, Our AMA (H-95.932) along with the WHO and CDC respec recognize the importance of increased access to naloxone and advocate for its widespread availability[29,30]; therefore be it

RESOLVED, That our American Medical Association oppose any policies that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked or monitored by non-health care providers. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution takes an important step to destigmatize the purchase of naloxone during the opioid crisis by proposing that the AMA support guidelines allowing any person be able to purchase naloxone without being tracked or monitored, and that the AMA oppose any policies that may require such prescriptions be tracked or monitored.
This resolution details the unnecessary tracking and monitoring of naloxone purchasing in certain states, how tracking naloxone purchases may discourage people from buying the life-saving drug, thus decreasing its accessibility. Because the AMA strongly supports the widespread availability and usage of naloxone to decrease the number of opioid related deaths (H-95.932) but has not yet taken a stance on potential tracking and monitoring of naloxone purchases, we believe that this resolution falls within the scope and spirit of the AMA and addresses an important gap in current policy.

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RELEVANT AMA POLICY

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription. (BOT Rep. 22, A-16, Modified: Res. 231, A-17, Modified: Speakers Rep. 1, A-17, Appended: Res. 909, I-17, Reaffirmed: BOT Rep. 17, A-18, Modified: Res. 524, A-19)

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Res. 526, A-06, Modified in lieu of: Res. 503, A-12, Appended: Res. 909, I-12, Reaffirmed: BOT Rep. 22, A-16, Modified: Res. 511, A-18, Reaffirmed: Res. 235, I-18)

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs. (BOT Rep. 3, A-08, Reaffirmed: BOT Rep. 12, A-15, Reaffirmation: A-16, Appended BOT Rep. 13, A-17)

Prescription Drug Monitoring Program Confidentiality H-95.946
Our AMA will:
(1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial;
(2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and
(3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred. (Res. 22, A-12, Reaffirmed: BOT Rep. 12, A-15, Reaffirmed: BOT Rep. 5, I-15)

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard,

emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
2. Our AMA:
A. promotes physician training and competence on the proper use of controlled substances;
B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81, Reaffirmed: CLRPD Rep. F, I-91, Reaffirmed: Sunset Report, I-01, Reaffirmed: CSAPH Rep. 1, A-11, Appended: Res. 907, I-11, Appended: Res. 219, A-12, Reaffirmation: A-15, Reaffirmed: BOT Rep. 12, A-15, Reaffirmed: BOT Rep. 5, I-15, Reaffirmed: BOT Rep. 17, A-18, Modified: Speakers Rep., A-18)

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs. (BOT Rep. 11, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(JUN-21)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee B

Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and Immigration Services (USCIS) are as follows:

1. You must be a U.S. Citizen.
2. If you are unmarried, you must be at least 25 years old.
3. If you are married, you must jointly adopt the child (even if you are separated but not divorced), and your spouse must also be either a U.S. citizen or in legal status in the United States.
4. You must meet certain requirements that will determine your suitability as a prospective adoptive parent, including criminal background checks, fingerprinting, and a home study[1]; and

Whereas, The federal government currently allocates funding for adoption and foster care to states, which independently manage federal funds and have differing statutes concerning eligibility to adopt or place a child up for adoption[2-4]; and

Whereas, Independent state-licensed child welfare agencies are contracted by each state to provide foster care or adoption services[5]; and

Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how "state-sanctioned discrimination against LGBT individuals who wish to raise children has dramatically increased in recent years"[6-7]; and

Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of children with LGBTQ individuals and same-sex couples and fourteen additional states lack explicit protection for LGBTQ individuals concerning adoption rights[5]; and

Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283 total children in the U.S. foster care system with 125,422 children waiting to be adopted[8]; and

Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the system[8]; and

Whereas, The longer a child is in foster care, the more likely that child is to move from one foster placement to another, and the greater the risk that child experiences adverse childhood events (ACEs), which may result in lasting negative social and emotional consequences[9]; and

Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster care with no known internal or external problems show an increase in “total problem behavior” in direct correlation with their number of placements[10-12]; and

Whereas, Frequent placement changes result in difficulty forming secure attachments with foster parents, low-self esteem, and a negative relationship with academic growth[10-12]; and

Whereas, Per the Centers for Disease Control and Prevention, “Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential”[13]; and

Whereas, Recent social science literature supports that children living with same-sex parents have equivalent outcomes compared to children with different-sex parents[14]; and

Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to adopt children under age 18 compared to different sex couples[15-16]; and

Whereas, Current AMA Policy H-60.959 calls for the “comprehensive and evidence-based care that addresses the specific health care needs of children in foster care” and supports the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children;” and

Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of their co-parenting partner but does not adequately address adoption rights of LGBTQ individuals nor their limited eligibility or access to adoption, allowing for potential harm towards children by narrowing the pool of qualified foster and adoptive homes; therefore be it

RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution address equal access to adoption for the LGBTQ community.
Our delegation believes it is imperative to continue to decrease the stigma and discrimination not only for those children who have yet to be adopted, but for the innumerable children parented by same-sex couples today. Moreover, there is also a vital function of a more equitable and available adoption process for same sex couples. By expanding the federal requirements for non-discrimination in relation to same sex parents, great strides could be made in addressing the epidemic of LGBTQ youth homelessness. Furthermore, the Supreme Court recently heard arguments on this very topic, experts believe the Supreme Court is likely to rule in favor of the Catholic adoption agency and thus against LGBTQ+ same sex parents/couples. This resolution would bolster existing AMA advocacy efforts.

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RELEVANT AMA POLICY

Uniformity of State Adoption and Child Custody Laws H-60.959
The AMA urges: (1) state medical societies to support the **adoption** of a Uniform **Adoption** Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform **Adoption** Act; and (3) state medical societies to support **adoption** of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and **adoption** of children.
Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based **care** that addresses the specific health **care** needs of children in **foster care**.
Res. 907, I-17

Partner Co-Adoption H-60.940
Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

Health Care disparities in Same-Sex Partner Households H-65.973
Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.
CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

Adoption H-420.973
It is the policy of the AMA to (1) support the provision of **adoption** information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of **adoption**.
Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(JUN-21)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

Whereas, "Mental health courts" are correctional diversion and rehabilitation programs used by state and local courts to support individuals with mental illness in the justice system[1-7]; and

Whereas, Mental health courts connect individuals with mental illness to mental health treatment, as an alternative to incarceration or other legal sentences and penalties[1-7]; and

Whereas, Two pieces of federal Congressional legislation, the America's Law Enforcement and Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and resources in the justice system and to establish grants to fund mental health court programs[8-9]; and

Whereas, The continued funding of MIOTCRA programs over the last two decades has been dependent on Congressional appropriations[10]; and

Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA) in the Department of Justice administer grants to fund state and local mental health courts[11,12]; and

Whereas, Research demonstrates that mental health courts appear to be associated with reductions in recidivism, length of incarceration, severity of charges, risk of violence, and rehospitalization among individuals with mental illness in the justice system[3,13-26]; and

Whereas, SAMHSA published a 2015 report noting that because "the vast majority of individuals who come into contact with the criminal justice system appear" before municipal courts and "many of these individuals have mental illness and co-occurring substance use disorders," municipal courts may be an especially effective "and often overlooked" method of diversion of individuals with mental illness from the justice system[26]; and

Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center, the National Sheriffs' Association, the Council on State Governments, and the National Center for State Courts, support the use of mental health courts[2,27-32]; and

Whereas, While several hundred mental health courts exist across all 50 states, mental health courts do not exist in all counties and localities, indicating that these programs may not be accessible or available to all individuals who could benefit from them[4]; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA[10-12], the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

Whereas, Courts that connect individuals with mental illness to treatment as an alternative to incarceration exist under many different names, with each focused on different types of mental illness, including "mental health courts" (for mental illness in general), "drug courts" (for substance use disorders), and "sobriety" or "sober courts" (for alcohol use disorder and sometimes certain other substance use disorders)[32-35]; and AMA policy should be inclusive of all these different types; and

Whereas, At I-19, a similar version of this resolution was adopted by our AMA-MSS as Policy 345.021MSS, establishing support for "mental health courts, including drug courts and sober courts…for individuals with mental illness and substance use disorders who are convicted of nonviolent crimes"; and

Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts, which are similar in function to mental health courts but narrower in scope, "for individuals with addictive disease who are convicted of nonviolent crimes"; and

Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran courts, which are similar in function to mental health courts but narrower in scope, "for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder"; and

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts[36-37]; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses[36]; and

Whereas, To be consistent with our HOD's most recent debate on this matter, Policy H-100.955 on drug courts and any future AMA policy on alternatives to incarceration for individuals with mental illness should not be limited to only nonviolent offenses; therefore be it

RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be amended by addition and deletion to read as follows:

Support for Mental Health ~~Drug~~ Courts, H-100.955
Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution seeks to amend current AMA policy supporting the use of drug courts in a more expansive manner toward support of "mental health courts." These are special courts comprised of judges, prosecutors, defense attorneys, and other personnel with expertise in mental health designed to rehabilitate persons with mental illness and decrease the percentage of persons with mental illness incarcerated without the appropriate treatment. Mental health courts have been shown to decrease recidivism, risk of violence, and re-hospitalization among individuals with mental illness in the justice system.
Our delegation prioritizes behavioral health equity and parity. This resolution would ensure that individuals with mental illness involved in the justice system are connected to mental health services and are not unjustly incarcerated or oppressed due to a treatable and manageable illness.

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
Res. 201, A-12; Appended: BOT Rep. 09, I-19

Support for Veterans Courts H-510.979
Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.
Res. 202, I-19

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Res. 116, A-12; Reaffirmation A-15

Support for Justice Reinvestment Initiatives, H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.
Res. 205, A-16

Prevention of Impaired Driving H-30.936 (excerpted)
Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;
CCB/CLRPD Rep. 3, A-14

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.
In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician’s diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.
AMA Principles of Medical Ethics: I,III (Code of Medical Ethics Opinion, Issued: 2016

Decisions for Adult Patients Who Lack Capacity, E-2.1.2
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.
When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
(ii) the patient's views about life and how it should be lived;
(iii) how the patient constructed his or her life story; and
(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.
AMA Principles of Medical Ethics: I,III,VIII (Code of Medical Ethics Opinion, Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(JUN-21)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee B

Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime rate taking place on rental properties by penalizing property owners if repeated incidents of nuisance activity occur over a set period of time (typically, 12 months)[1]; and

Whereas, CNOs are part of a phenomenon called "third-party policing," through which cities require private citizens – in this case property owners – to address criminal or otherwise undesirable behaviors[1]; and

Whereas, Punishments for violating CNO's may range from warning letters and fines to evictions and building closures, and often involve a "nuisance point system" where a certain number of accumulated points will result in eviction and other actions[1]; and

Whereas, What qualifies as nuisance activity can vary widely between municipalities, though commonly defined as the amount of contact with emergency services, first responders, and police, for criminal behavior that occurs on or near the property, or "alleged nuisance conduct" (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and others)[2]; and

Whereas, CNO's have been enacted by an estimated 2,000 municipalities across 44 states as of 2014 [3]; and

Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the source, of the nuisance activity[3,17]; and

Whereas, CNOs punish tenants who require police and emergency medical assistance by making eviction a consequence of police responses to their homes[1]; and

Whereas, The reason for calling the police is not taken into account by most CNOs, so people who experience mental health crises may be deemed perpetrators of nuisance activity for seeking emergency medical assistance at a frequency beyond the threshold established in the CNO and may be threatened with eviction by their landlords[1]; and

Whereas, Cities have fined group homes (organizations that provide community-based residences for people with disabilities) after staff sought police or emergency services assistance responding to their residents' medical emergencies[15]; and

Whereas, Health crises that can count as a CNO violation include drug overdoses: public records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are related to a person experiencing a drug overdose, many of which explicitly include violations of criminal drug abuse laws as nuisance[15]; and

Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as litter, an un-mowed lawn, or an "unsightly" yard, which can be applied against residents whose physical, mental, or health-related disabilities prevent them from meeting their municipality's maintenance standards[1]; and

Whereas, In June 2017, an appellate court struck down the Village of Groton's nuisance law as unconstitutional under the First Amendment, the reasoning being that it deterred tenants from seeking police assistance, and discouraged people, including domestic violence victims, from reaching out for help[4]; and

Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that chronic nuisance ordinances disproportionately impact people of color[2]; and

Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many nuisance enforcement actions in the quarter of the city with the highest concentration of people of color as it did in the quarter with the lowest concentration of people of color[2]; and

Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois revealed that properties in predominantly black neighborhoods were more than twice as likely to be cited under the city's nuisance ordinance as white neighborhoods[5]; and

Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly black neighborhoods were over two and a half times as likely to receive a nuisance citation as properties in predominantly white neighborhoods, even when the neighborhoods made similar numbers of calls[6]; and

Whereas, Women with disabilities have a 40% greater chance of experiencing domestic violence than women without disabilities[8]; and

Whereas, There are an estimated 1.3 million women who are the victims of assault by an intimate partner annually, and women have a 25% lifetime risk of intimate partner violence[7]; and

Whereas, Congress acknowledges that "women and families across the country are being discriminated against, denied access to, and even evicted from public and subsidized housing because of their status as victims of domestic violence" [7]; and

Whereas, Domestic violence advocates' efforts in the past decades have been focused on educating law enforcement on how to approach and aid victims in escaping the cycle of domestic violence while maintaining their housing[3]; and

Whereas, This initiative is directly being threatened by CNOs, as calls about domestic disturbances can result in the eviction of everyone in the household[3,10-13]; and

Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by residents experiencing domestic violence even in cases where exceptions exist, calls placed by survivors of domestic violence are regularly miscategorized and the tenants are punished under the CNO regardless[9]; and

Whereas, Such punishment of domestic violence-related calls for police and medical services discourages victims of domestic violence from seeking help in future assaults[10]; and

Whereas, The use of CNOs may contribute to the "double victimization" of domestic violence victims, who may be evicted because of allegations of disturbing other tenants or property damage caused by their abusers, and thus are more likely to hide the abuse rather than seek help like emergency services[11]; and

Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing nuisance activity is limited[6,9,12]; and

Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such behavior[12]; and

Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety, and even suicide[14,18]; and

Whereas, Individuals who lost legal rights to their housing and whose landlords applied for eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to individuals who had not experienced eviction[16]; and

Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or victims of domestic violence limit the opportunities for these tenants to find affordable housing in the future, regardless of the circumstances in which they occurred[13]; therefore be it

RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services, are not counted towards nuisance designations (Directive to Take Action); and be it further

RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance enforcement and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution seeks to advocate for changes in procedure to Chronic Nuisance Ordinances (CNOs) and to support initiatives that increase the data available on CNOs.
Cities across 44 states in the US have enacted Chronic Nuisance Ordinances (CNOs), which are municipal laws that penalize landowners and tenants when emergency services or law enforcement are called frequently to the premises. Importantly, CNOs in many municipalities do not distinguish between victims and perpetrators of nuisance activities. Numerous health crises can count as a CNO violation including drug overdoses, domestic or partner violence, and even mental health crises. As a consequence, tenants who require frequent police or emergency medical assistance may face threats of eviction and encounter discrimination when applying to housing. Thus, the enforcement of CNOs can penalize callers to the police and emergency services for assistance regardless of the situational context. CNOs are a serious detriment to our mission as physicians to "do no harm". Our AMA should advocate for the amendment of CNOs to ensure that residents are not reprimanded in situations where they are victims.

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(JUN-21)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical treatment to their country of origin by healthcare professionals[1]; and

Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign country, provoking an unwarranted intersection between immigration enforcement and the healthcare system[2]; and

Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017, a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall healthcare spending in a population with the highest risk of being uninsured among the non-elderly population[2-4]; and

Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally funded health institutions with emergency care capabilities are mandated to treat all patients with emergent medical conditions who present to their facility until deemed stable, regardless of their insurance coverage or financial status[5]; and

Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-term care alternative is available to the patient as a cost-saving mechanism[6]; and

Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona partake in forced medical repatriation for undocumented immigrant patients and a Florida patient experienced involuntary deportation prior to the completion of their appeal or asylum verdict[7-9]; and

Whereas, Forced medical repatriation has led to serious medical consequences for patients, including the exacerbation of existing medical conditions[10,11]; and

Whereas, Patients experienced a lapse and deterioration of care due to the inability of the patient's country of origin to provide adequate treatment and concurrent separation from their community in the U.S. during a time which may require emotional, physical and financial support[6,7,9,12]; and

Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical consequences related to repatriation[7,13]; and

Whereas, Forced medical repatriation increases health disparities among migrant communities and deters immigrants from seeking necessary medical services[14,15]; and

Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid Services' Conditions of Participation regulation which commits hospitals to ensure patients have the right to conduct informed decisions regarding their care[16,17]; and

Whereas, Forced medical repatriation violates the patient's constitutional right to due process, especially if the patient is able to claim asylum[18]; and

Whereas, The AMA *Journal of Ethics* encourages health care systems to seek routes of care to avoid forced medical repatriation and the AMA Code of Ethics Opinion 1.1.8 states that "physicians should resist any discharge requests that are likely to compromise a patient's safety" and that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations" [2,19,20]; and

Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for Safety Net Care for Undocumented Aliens (H-160.956)[21,22]; and

Whereas, Data on repatriation of civilians is not reported through any government agency or otherwise, and there is a lack of documentation[7,23]; therefore be it

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The resolution denouncing the practice of forced repatriations in accordance to our ethical standards addressed a unique problem and proposes a change to existing policy. It clearly addresses an important ethical dilemma and public health crisis as a result of forced medical repatriations on our vulnerable immigrant communities and seeks to address forced medical repatriation by proposing an amendment to H-350.957. Currently, there is no mention of medical repatriation in existing AMA policies and under the current political climate revolving immigrant health, we feel that this obviously unethical practice urgently needs to be researched and denounced by our AMA. We believe that this is the natural progression of our nation's medical society towards caring for one of our most disenfranchised members of society.

By advocating for data collection and documentation of repatriation cases, this resolution also demands transparency into an issue that has been rendered invisible due to a lack of data. We believe that this resolution represents a timely and positive step forward during a time in which immigrant health has come under threat.

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RELEVANT AMA POLICY

Limit Scope of EMTALA to Original Legislative Intent D-130.994

(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.

(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the

discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.
(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting. (Sub. Res. 217, I-00, Reaffirmed: BOT Rep. 6, A-10)

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

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
(C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.
(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.
(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care. (CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18)

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

Emergency Transfer Responsibilities H-130.957
Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to: (1) require that the Office of the Inspector General (IG) request and receive the review of the Peer Review Organization (PRO) prior to imposing sanctions; (2) make the PRO determination in alleged patient transfer violations binding upon the IG; (3) expand the scope of PRO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks; (4) restore the knowing standard of proof for physician violation; (5) recognize appropriate referral of patients from emergency departments to physician offices; (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer; (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient; (8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act. (Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10)

Repeal of COBRA Anti-Physician Provisions H-130.959
It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility. (Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10)

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19)

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14)

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. (Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19)

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities. (Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. (Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(JUN-21)

Introduced by: Medical Student Section

Subject: Using X-Ray and Dental Records for Assessing Immigrant Age

Referred to: Reference Committee B

Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-rays, which together are compared to growth charts to determine the age of an individual[1]; and

Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs, and dental X-rays may not correlate with the true chronological age of an individual due to population and geography-specific factors, including nutritional intake, environmental exposure, and genetics to such an extent that the Centers for Disease Control (CDC) recommends against using hand-wrist radiographs to determine the age of refugees[1-5]; and

Whereas, International records highlight the wide variety in growth charts utilized country to country, in part due to different genetics, nutrition, medical conditions, and environmental exposures[6,7,8]; and

Whereas, The Department of Homeland Security (DHS) and the Department of Health and Human Services (HHS) will request new skeletal and dental x-ray imaging to establish the age of an individual crossing the border[9]; and

Whereas, According to Food and Drug Administration recommendations, performing x-rays on children comes with greater risk of radiation-related illness and should only be used to answer a clinical question or to guide treatment[10]; and

Whereas, The DHS handbook, in collaboration with the Office of Refugee Resettlement , which is part of HHS, states that medical images may be used only when no other means of verifying chronological age exist[9,11]; and

Whereas, The DHS handbook states that acceptable documentation to verify chronological age can include official government-issued documents such as a birth certificate, other governmental records, a baptismal certificate, school records, medical records, or other objective documentation with a date of birth listed[9]; and

Whereas, If the immigrant/refugee does not have their birth certificate, the DHS handbook states that affirmative steps should be taken to contact the refugee's home country's relevant record keeping department to verify their birth date[9]; and

Whereas, The DHS handbook directs immigration officers to accept statements by the person in question, their family members, other people who know the person as verifying evidence[9]; and

Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for

child age determination and has since decreased their use of age determination exams [12,13]; and

Whereas, In 2018, ICE decreased the number of age determination exams it used to less than 50; meanwhile, HHS increased its utilization of the exams for those in the care of the ORR to almost 700 , almost double the number granted to both agencies in each of the prior two years[13]; and

Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are held in adult detention centers while waiting for their cases to be heard and therefore are not held in the least restrictive setting, in violation of the federal government's promise to do so in the Flores Agreement and further restricting their rights [14]; and

Whereas, Attorneys representing minors report that their clients' supporting documentation was not used and were instead placed in adult detention centers solely based on x-ray images for months until federal judges ruled that ICE and HHS could not classify their immigrant clients as adults based solely on imaging[15]; and

Whereas, As an example, one 19-year-old woman immigrating to the U.S. on a fiancée visa was incorrectly deemed a minor based on dental and hand-wrist radiographs and was not released to her aunt, resulting in her involuntary detainment in a shelter for minors for 14 months[16]; and

Whereas, Existing AMA policy H-65.958 states that the AMA will advocate for the healthcare services provided to minor immigrants, both in detention and those held at border patrol stations; and

Whereas, Existing AMA policy H-315.966 states that the AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented; therefore be it

RESOLVED, That our American Medical Association support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant's age. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections towards vulnerable and marginalized members in our society, including immigrants and refugees. This resolution addresses the inappropriate use of dental and bone X-rays in determining immigrant person's age. This resolution contains data suggesting bone and dental forensics are inadequate measures for determining age in immigrants crossing the US border who have other documentation, and the harm this practice causes. Not only can the unnecessary use of medical imaging increase radiation exposure to children but this technology has also been shown to be an imprecise and inaccurate method of age determination. There are current reports of minors being held in adult detention camps due to ICE policy that encourages the use of X Rays and dental records over self-reported or even documented age. We believe that this resolution represents a novel, and timely action taken on behalf of an incredibly vulnerable population and thus ask the House's consideration.

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RELEVANT AMA POLICY

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. (Res. 013, A-19)

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (CSA Rep. 4, A-03 Modified: Res. 2, I-10 Modified: Res. 254, A-18)

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (Res. 018, A-17)

Reference Committee C

CME Report(s)

01* Council on Medical Education Sunset Review of 2011 House Policies

02* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses

03* Optimizing Match Outcomes

04* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice

05* Promising Practices Among Pathway Programs to Increase Diversity in Medicine

Resolution(s)

301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

302 Non-Physician Post-Graduate Medical Training

303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE

304* Decreasing Financial Burdens on Residents and Fellows

305* Non-Physician Post-Graduate Medical Training

306* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training

307* Updating Current Wellness Policies and Improving Implementation

308* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure

309* Supporting GME Program Child Care Residency Training

310* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine

311* Student Loan Forgiveness

312* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs

313* Fatigue Mitigation Respite for Faculty and Residents

314* Standard Procedure for Accommodations in USMLE and NBME Exams

315* Representation of Dermatological Pathologies in Varying Skin Tones

316* Improving Support and Access for Medical Students with Disabilities

** Contained in the Handbook Addendum*

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-JUN-21

Subject: Council on Medical Education Sunset Review of 2011 House Policies

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

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

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

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

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

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

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

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RECOMMENDATION

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

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Texts	Recommendation
H-210.986	Physicians and Family Caregivers - A Model for Partnership	Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of caregiver stress and burden; (2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care; (3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and (4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver. Citation: (CSA Rep. I, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; duplicative of H-210.980, "Physicians and Family Caregivers: Shared Responsibility," which reads: "Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and (5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients."

D-295.322	Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools	Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. (Res. 313, A-09; Modified: CME Rep. 6, A-11)	Retain; remains relevant, especially due to increased attention to the need for diversity in medical education and practice.
H-295.888	Progress in Medical Education: the Medical School Admission Process	1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. 2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. (CME Rep. 8, I-99;	Retain; remains relevant, as the AMA's Accelerating Change in Medical Education initiative and other activities seek to improve the selection process for medical students (and change the composition and diversity of the future physician workforce).

		Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)	
H-305.962	Taxation of Federal Student Aid	Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-305.997	Income Tax Exemption for Medical Student Loans and Scholarships	The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by H-305.962, "Taxation of Federal Student Aid," which reads: "Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA)."
H-40.994	Military Physicians in Graduate Medical Education Programs	Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by H-40.995, "Graduate Medical Education in the Military," which reads, in part: "Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; … 5) oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for an equal number of

			civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage."
D-180.995	Physician Privileges Application - Timely Review by Managed Care	Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain; still relevant.
D-255.982	Oppose Discrimination in Residency Selection Based on International Medical Graduate Status	Our AMA: 1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants. 2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience. 3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. (Sub. Res. 305, A-08; Reaffirmation I-11)	Rescind. Clause 1 is reflected in ACGME Institutional Requirement IV.1.5, "Discrimination: The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. (Core)" Clause 2 is superseded by H-255.988 (11), "AMA Principles on International Medical Graduates," which reads, "That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an

			ethnic name as a negative factor." Also reflected in H-255.983, "Graduates of Non-United States Medical Schools," which reads, "The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character." Clause 3 was accomplished at the time of adoption of the resolution.
D-275.993	Reporting of Resident Physicians	Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit~~, consistent with existing AMA Policy H-265.934 (#4)~~; (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4-I-01; Reaffirmed CME Rep. 2-A-11)	Retain in part. Policy H-265.934 is no longer AMA policy, hence the deletion in clause 1.
D-305.992	Accounting for GME Funding	Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our	Retain; remains relevant. See also H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs":

		AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11)	"4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead."
H-310.911	ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities	Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy. (Res. 317, A-11)	Retain; remains relevant. See also H-310.905, "Scholarly Activity by Resident and Fellow Physicians."
H-310.959	In-Service Training Examinations - Final Report	It is the policy of the AMA ~~(1)~~ to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards~~; (2)~~	Retain in part. Clause 1 is still relevant. For clauses 2 and 3, the Accreditation Council for Graduate Medical Education is using Milestones and multiple measures of evaluation.

		~~to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents~~. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Relying on one metric is frowned upon. (see Sections V.A.1 Resident Feedback and Evaluation and V.A.2 Resident Final Evaluation.)
H-310.960	Resident Education in Laboratory Utilization	Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-310.996	Residency Review Committee Representation	Our AMA: (1) supports resident membership on Residency Review Committees; (2) requests that the resident representatives to the Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serve for at least a one-year term as a full and voting participant at all RRC meetings; (3) requests that the resident members of the RRCs be peer-selected; and (4) will advocate for diversity of appointees to RRCs. (Res. 67, I-82; Reaffirmed: Sub. Res. 186, A-87; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 306, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: Res. 304, A-11)	Rescind; is now reflected in ACGME documents, including ACGME Policies and Procedures, Subject: 9.00 Review Committees and Recognition Committee: "(8) Member Appointment – Nominating organizations should submit to the ACGME administration the names of two candidates for each vacancy at least 12 months before the date of the appointment. Nominating organizations should consider professional qualifications, geographic distribution, and diversity in nominating their candidates." Also reflected in Committees and Members Selection

			Process: "Review Committees have physician members, at least one of whom is a resident at the time of appointment, and a public member. "Appointment of Resident Members to Review Committees "The process takes approximately 12 months from the call for nominations until the member's term begins. The Review Committee Executive Director requests nominations through the ACGME e-Communication and/or via letter to the specialty-specific professional organizations that have resident groups."
H-410.986	Resident Involvement in Practice Parameters	Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. The intent of this policy is being met, as many specialty societies include residents/fellows on committees on development of guidelines for physician practice.
D-140.981	Ethical Guidelines on Gifts to Physicians from Industry	Our AMA shall: (1) communicate to all medical school deans and residency program directors the importance of including education on ethical guidelines regarding gifts to physicians from industry within the ethics curriculum of their medical student and housestaff education programs; (2) communicate to all medical school deans and residency program directors the content of CEJA Opinion E-8.061 and shall recommend that it or another nationally-recognized ethical guideline be used as the basis for educational content on this issue; (3) recommend to all medical school deans and residency program directors that appropriate policies be developed for medical students, housestaff and faculty in their respective institutions regarding the issue of gifts to physicians from industry; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to encourage the Liaison	Rescind. This directive has been accomplished.

		Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure databases that exist or will be created by 2013 as required by the Patient Protection and Affordable Care Act; and (5) work with AAMC and AACOM to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (Res. 13, A-02; Reaffirmed: Res. 303, A-05; Appended: Res. 308, A-11)	
H-275.993	Examinations for Medical Licensure	Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. This is in essence the role of medical school faculties, and the essence of medical school accreditation.
H-295.868	Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training	1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs. 2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness. 3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians. ~~4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.~~ ~~5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).~~ ~~6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.~~	Retain in part. Still timely, with deletion of clauses 4-7, as these are no longer relevant.

		~~7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.~~ 4~~8~~. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices. 5~~9~~. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision. 6~~10~~. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency. 7~~11~~. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers. 8~~12~~. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency. (CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11)	
H-310.970	Mandatory Helicopter Flight for Emergency Medical Residents in Training	Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset	Rescind; superseded by H-295.943, "Issues Regarding Patient and/or Donor Transports by Resident

		Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20)	Physicians and Medical Students.""
H-295.943	Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students	Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsorily or voluntarily) in the air or ground transport of patients or organs (a) to notify prospective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines for transport. (CME Rep. E, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant. See also H-310.970, "Mandatory Helicopter Flight for Emergency Medical Residents in Training," which is being rescinded through this report, as it is superseded by H-295.943.
D-305.990	Impact of Health System Changes on Medical Education	Our AMA wil continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; remains relevant, but superseded by H-305.942, "The Ecology of Medical Education: The Infrastructure for Clinical Education," which reads: "The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty

			distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians."
D-405.987	Debilitating Accidents and Accidental Deaths of Physicians in Training	Our AMA: 1) requests modification in the annual survey distributed to medical schools in order to assess the topic of serious accidents and accidental deaths; 2) requests modification of other annual surveys of medical schools, residency directors, and other medical educators in order to assess the topic of serious accidents and accidental deaths among physicians in training. (Res. 323, A-11)	Rescind; this directive was accomplished.
H-435.997	Medical School Malpractice Risk Prevention Curriculum	Our AMA (1) acknowledges the continuing and growing severity of the problem of physician professional liability insurance nationwide and (2) urges medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of sound risk management to clinical practice. (Sub. Res. 48, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed:	Rescind; superseded by H-295.924, "Future Directions for Socioeconomic Education," which reads: "The AMA: (1) asks medical schools and residencies to encourage that basic

		Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum."
G-615.060	CME Activities	Our AMA supports intensified efforts of the Council on Medical Education and other bodies within our AMA to initiate meetings and encourage continuing dialogue with medical students, interns, and residents. (Sub. Res. 22, I-69; CME Rep. I, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11)	Rescind; this work is already reflected in multiple AMA activities and initiatives, including the Medical Student Section and Resident and Fellow Section (neither of which were in existence in 1969, when this policy was adopted).
H-300.946	Inappropriate Use of Social Security	Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain	Retain; remains relevant.

	Numbers in CME Accreditation	continuing medical education credit and strongly encourage the use of the AMA Medical Education number for such educational activities; and (2) file identifiers by providers of continuing medical education, certification boards and similar entities, suggesting instead the use of the AMA Medical Education number where such a unique identifier is required and applicable. (Res. 306, A-00; Appended Res. 301, A-01; Reaffirmed: CME Rep. 2, A-11)	See also H-190.963, "Identity Fraud," which reads: "Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation."
D-300.980	Opposition to Increased CME Provider Fees	1. Our AMA will ~~(a) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA's requests this past year~~; (a~~b~~) continue to work with the ACCME to: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes, (iii) improve continuing medical education, and (iv) encourage the ACCME to show that ~~the updated~~ accreditation criteria improve patient care; and (b~~e~~) continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (ii) reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees." ~~3. Our AMA, in collaboration with the ACCME, will do a comprehensive review of the CME process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.~~ (CME Rep. 14, A-10; Appended: CME Rep. 9, A-11; Modified: CCB/CLRPD Rep. 4, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 302, A-17)	Retain in part. Delete 1.(a) and 3, which have been accomplished, and delete "updated" in 1.(b)(iv), in that these criteria were revised in the past. As stated in Council on Medical Education Report 7-A-12, the Council monitored results of the recommendations from Policy D-300.980 for the prior three years, and the Accreditation Council for Continuing Medical Education has been amenable to discussing AMA concerns. In December 2009, the ACCME created a task force to explore strategies for clarifying the requirements, eliminating redundancies, and reducing the documentation requirements for providers. This Task Force reported back to the ACCME Board in November 2010. The ACCME reports that it continues to be actively engaged in ongoing discussions and that some of the "simplification" changes associated with

			the Task Force's work have already been implemented. For the past three years, the AMA has advocated for reduced fees and changes to the existing ACCME accreditation system. The Council on Medical Education will continue to monitor the activities and fees of the ACCME.
H-300.973	Promoting Quality Assurance, Peer Review, and Continuing Medical Education	Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-300.974	Unification of Continuing Education Credits	Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to *AMA PRA Category 1 Credit™*. (CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01; Modified: CME Rep. 2, A-11)	Retain; remains relevant.
H-300.975	Fraudulent/ Legitimate Continuing Medical Education Activities	Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
D-300.979	Suggested Revision in	~~1.~~ Our AMA will: ~~(1) strongly encourage the Accreditation Council for Continuing Medical~~	Retain in part with the deletion of (1) and

	ACCME Evaluations	~~Education to recognize the value of gaining knowledge outside a physician's specialty and change the activity evaluation to reflect this; and (2)~~ communicate to the Accreditation Council for Continuing Medical Education that programs on the history of medicine have relevance for improvements in physicians'~~?~~ knowledge and competence. (Sub. Res. 310, A-10; Appended: Res. 320, A-11)	editorial change to (2), along with the number 1., which is unneeded. Both (1) and (2) have been accomplished, but (2) is still relevant.
H-300.992	National Accreditation of AMA as Provider of Continuing Medical Education	Our AMA assigns to the ~~CME~~ Council on Medical Education the responsibility to be the unit of the AMA to become accredited for continuing medical education. (BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant, with editorial change to specify the "Council on Medical Education," to avoid confusion with "continuing medical education."
D-300.995	Reducing Burdens of CME Accreditation and Documentation	Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; accomplished. In 2017, the AMA and ACCME completed a multi-year process of simplification and alignment of the credit and accreditation systems. The process included multiple avenues of input from the CME community, culminating in a call for comment regarding proposed changes. The recommendations of the AMA/ACCME bridge committee were approved by the AMA Council on Medical Education and the ACCME Board of Directors.
D-300.998	Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures	Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner's care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS	Retain; remains relevant.

		(CME Rep. 2, A-01; Reaffirmed: CME Rep. 2, A-11)	
H-250.996	Enhancing Young Physicians' Effectiveness in International Health	It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-260.978	Salary Equity for Laboratory Personnel	It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; outside the scope of the AMA.
D-275.964	Principles of Due Process for Medical License Complaints	1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians'~~?~~ rights. 2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. (Res. 238, A-08; Appended: Res. 301, A-11)	Retain; still relevant. Note editorial change to clause 1 to fix error.
D-275.989	Credentialing Issues	~~1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.~~	Rescind in part. Clause 1 has been accomplished through work by the FSMB and ECFMG to replace paper-based processes with an electronic portal for medical school transmission of diplomas and transcripts for IMGs. These technological advances

		~~2.~~ Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials. (CME Rep. 3, A-02; Appended: CME Rep. 10, A-11)	have reduced turnaround time for credentials verification for the majority of applicants. Clause 2 should be retained, in that states should be encouraged to accept the ECMG certification as proof of primary source verification of an IMG's international medical education credentials, to ensure efficiency and reduced processing time for IMGs seeking licensure while protecting the public.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-JUN-21

Subject: Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (Resolution 311-A-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 311-A-19, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," introduced by the International Medical Graduates Section (IMGS), and referred by the House of Delegates, asked that our American Medical Association (AMA) work with the Federation of State Medical Boards (FSMB), the Organized Medical Staff Section, and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system.

Testimony on this item during the 2019 Annual Meeting from an international medical graduate (IMG) academic physician who has trained many residents and fellows in the United States, but who is ineligible to obtain a medical license, reflected the impetus for this item. A physician from Florida testified how that state continues to grapple with the issue of physician immigrants from Cuba and other countries who do not meet state licensure requirements yet seek to find a way in which to put their (often considerable) skills to work in their new country in service to patients and society.

BACKGROUND

All state medical boards require physicians to have completed at least one year of graduate medical education (GME) in a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) to be eligible for a full, unrestricted medical license.[1] Some states do issue limited, restricted licenses that allow a physician to practice, under supervision, in specific institutions. Some of these physicians are IMGs who not only received their medical education outside the U.S. but also trained in a specialty and practiced abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution utilizing one of these limited, restricted licenses, despite being ineligible for full licensure. Some institutions, however, have instituted changes to require that all physicians employed by the institution be board certified or board eligible. This has excluded physicians with restricted, limited licenses who may have been serving their community for years while contributing to patient care and the medical education of students and residents.

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RESTRICTED LICENSES

Medical boards issue a variety of licenses other than full, unrestricted licenses. Of relevance, 40 medical boards issue "faculty/educational" licenses; 44 issue "limited/special purpose" licenses, and 19 issue "institutional practice" licenses.[1] Medical boards may determine the limitations or conditions of practice under these licenses differently, as well as the educational and/or training requirements. In addition, the boards use different names for possibly similar types of licenses, making it challenging to quantify less common license types at the national level. For example, according to a requested analysis provided by the FSMB, 163 physicians nationwide possess a license categorized as "teaching." These licenses are labeled variously, such as "Foreign Teaching Physicians" or "Distinguished Faculty." This count could be low considering the variability in how medical boards categorize and share data for these less common license types.

For example, in Washington state, the Washington Medical Commission may "issue a limited license to a physician applicant invited to serve as a teaching-research member of the institution's instructional staff if the sponsoring institution and the applicant give evidence that he or she has graduated from a recognized medical school and has been licensed or otherwise privileged to practice medicine at his or her location of origin. Such license shall permit the recipient to practice medicine only within the confines of the instructional program specified in the application."[2]

Texas offers a faculty temporary license, with similar requirements as Washington, with specific restrictions concerning the institution that can hire the physician (i.e., certain medical centers, Texas medical schools, or GME sponsors).[3] The District of Columbia specifically offers licenses "for foreign doctors of eminence and authority."[4] New York offers a limited permit that can allow an IMG without U.S. GME to practice in a nursing home; state-operated psychiatric, developmental or alcohol treatment center; or incorporated, nonprofit institution for the treatment of the chronically ill, but only for up to four years.[5]

Florida offers a "house physician" license and provides a detailed description of the work that can be done, all under the supervision of a physician with an active, unrestricted Florida license. The license for house physicians does not require U.S. GME and seems to have relatively few requirements, i.e., types of institutions are not specified, nor time limits.[6]

BOARD CERTIFICATION REQUIREMENTS

The American Board of Medical Specialties (ABMS) acknowledges that there may be acceptable alternative pathways to initial certification for candidates who have not completed U.S. GME. Some ABMS member boards recognize alternative pathways, but others do not, due to the challenges associated with assessing equivalency of training for these medical specialties.[7]

The ABMS Position Statement on Alternative Pathways to initial certification defines the guiding principles for acceptable alternative pathways that do not meet the standard pathway (i.e., ACGME-accredited or Canadian-accredited GME). An ABMS workgroup is currently reviewing the ABMS Position Statement to determine if additional changes are required to ensure continued clarity.[7]

The ABMS stipulates that alternative pathway policies and procedures for initial certification should:

1. Be transparent, objective, equitable, and readily available to interested candidates and stakeholders;

2. Not be arbitrary or capricious to interested candidates and stakeholders;
3. Include the assessment of all six of the ABMS/ACGME core competencies;
4. Include the assessment of professional standing in adherence with the ABMS Professional Standing Policy; and
5. Adhere to Member Boards' existing Board Eligibility policies for both specialties and subspecialties, provided those policies adhere to the ABMS Board Eligibility Policies.

Sixteen boards offer pathways for internationally trained physicians; in particular, ten boards offer pathways for physicians practicing in the United States at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor); two boards will accept international training as meeting all of the training requirements on a case-by-case basis; and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. Two boards have established that training in Australia and New Zealand is equivalent to ACGME-accredited training; these boards will accept candidates who trained in those countries.

Twenty-two member boards accept all of a candidate's training in Canada (either accredited by the Royal College of Physicians and Surgeons of Canada [RCPSC], or by another body acceptable to the board). Of these, eleven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board).

Regardless of a member board's position on alternative pathways, it is the policy of the ABMS that, to be eligible for certification in any specialty or subspecialty and to maintain certification, a physician must have a full and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada.

EXPLORATION OF ALTERNATIVE PATHWAYS IN MINNESOTA

Minnesota's International Medical Graduate Assistance Program, operational since 2016, helps IMGs in the state obtain residency positions. One aspect of the program includes study of possible licensure changes that would allow qualified IMGs to practice in Minnesota. The Minnesota Department of Health, working with the Minnesota Board of Medical Practice and other stakeholders, proposed two possible strategies in 2018: the creation of an IMG Primary Care Integration license and an amendment to the medical practice act to include an exemption for practice in primary care in a rural or underserved area. Objectively qualified IMGs would be able to practice in areas experiencing primary care shortages without entering U.S. GME. The process includes passage of all licensure exams, demonstrating at least seven years of medical practice, participation in a six-month clinical experience, and an assessment that would culminate in a certificate that would allow work under supervision.

The program would require the commitment of an accredited assessor. Another concern is that these physicians would not be eligible for board certification and may encounter employment restrictions. Two major stakeholders—the Minnesota Academy of Physician Assistants and the Minnesota Medical Association—have raised objections, citing concerns over professional role confusion and a tiered licensure system. The Minnesota Department of Health continues to research possible licensure changes.[8,9]

CURRENT AMA POLICY

As shown in the appendix, the AMA has substantial policy that supports full licensure for practicing physicians, whether U.S. medical school graduates or IMGs, only after completion of at least one year of GME in the U.S. (see H-255.988 [12] and H-275.934 [2]).

Policy H-160.949 (6) specifies as well that the AMA "opposes special licensing pathways for physicians who are not currently enrolled in an [accredited]...training program." This policy was adopted at the 2014 Annual Meeting in response to development in Missouri of a special licensure pathway for practice by "assistant physicians" who have not had any GME in the U.S. (see https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/). Meanwhile, Policy H-275.978 (5) states that the AMA "urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public." It would seem that these two policies are contradictory; accordingly, they are proposed for modification in the recommendations below.

In addition, the AMA both recognizes the value of board certification but advocates against discrimination against physicians based on a lack of board certification. Policy H-220.960 asks The Joint Commission to "support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards...that board certification is an excellent benchmark for the delineation of clinical privileges." At the same time, H-275.926 states that the AMA "(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination."

SUMMARY AND RECOMMENDATIONS

Existing AMA policy is of two minds in terms of the requirements for full licensure and board certification. Indeed, the need for an expanded workforce, to meet the growing needs of patients for access to health care services, must be balanced with requisite caution in awarding licensure for practice, given the need to protect the public and ensure the quality of the medical workforce. Given, however, that physicians who have been serving their communities for years may have their careers jeopardized as a result of employers adopting new employment standards, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 311-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) encourage state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification. (Directive to Take Action)

2. That our AMA amend Policy H-255.988 (12), "AMA Principles on International Medical Graduates," by addition to read as follows:

   Our AMA supports …12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community. (Modify Current HOD Policy)

3. That our AMA amend Policy H-275.934 (2), "Alternatives to the Federation of State Medical Boards Recommendations on Licensure," by addition to read as follows:

   2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community. (Modify Current HOD Policy)

4. That our AMA amend Policy H-160.949 (6), "Practicing Medicine by Non-Physicians," by addition and deletion to read as follows:

   Our AMA … (6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education ~~of American Osteopathic Association~~ training program, or have not completed at least one year of accredited ~~post-~~graduate ~~US~~ medical education in the U.S). (Modify Current HOD Policy)

5. That our AMA amend Policy H-275.978 (5), "Medical Licensure," by addition to read as follows:

   Our AMA … (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for "assistant physicians." It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (Modify Current HOD Policy)

Fiscal Note: $1,000.

APPENDIX

H-160.949, "Practicing Medicine by Non-Physicians"

Our AMA . . . (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

H-220.960, "The Joint Commission Hospital Accreditation Program Standards"

Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges….

H-255.966, "Abolish Discrimination in Licensure of IMGs"

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

H-255.970, "Employment of Non-Certified IMGs"

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure.

H-255.988, "AMA Principles on International Medical Graduates"

Our AMA supports:

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

H-275.926, "Medical Specialty Board Certification Standards"

Our AMA: (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

H-275.934, "Alternatives to the Federation of State Medical Boards Recommendations on Licensure"

Our AMA adopts the following principles: (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine.

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience….

H-275.978, "Medical Licensure"

Our AMA: (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

REFERENCES

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[7] American Board of Medical Specialties Committee on Certification (COCERT). December, 2020.

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[9] Hirsi I. Could the state-funded International Medical Graduate Assistance Program do more for immigrant doctors — and help address Minnesota's looming doctor shortage? MinnPost. May 11, 2018. https://www.minnpost.com/new-americans/2018/05/could-state-funded-international-medical-graduate-assistance-program-do-more-i/. Accessed December 30, 2019.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)
Optimizing Match Outcomes
(Resolution 304-I-19)
(Reference Committee C)

EXECUTIVE SUMMARY

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to the development of American Medical Association (AMA) policy and advocacy to increase residency training positions, and policy that promotes systems and programs to guide applicants to choose specialties and apply and match to residency training programs effectively. Recent technological problems with the application service used by unmatched applicants and unfilled training programs, the Supplemental Offer and Acceptance Program® or SOAP®, have increased the apprehension of medical students and physicians concerning their ability to enter graduate medical education.

Many medical education stakeholders, most notably the Association of American Medical Colleges (AAMC), but also the National Resident Matching Program (NRMP) and the AMA, have developed numerous tools and informational guides to help students select a specialty and then apply to, interview with, rank, and match to programs. In addition, U.S. medical schools have dedicated staff eager to help students successfully match into residency programs, providing accessible online advice as well as personal counseling. To further improve the system, pilots are currently being tested to provide optimal matching opportunities with the intent of decreasing anxiety during the application/interview/matching season, reducing superfluous applications, and increasing transparency between applicants and programs.

In the interim, key stakeholder organizations, such as the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information consistently and rationally if the desire is to successfully match to a program.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-JUN-21

Subject: Optimizing Match Outcomes (Resolution 304-I-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 304-I-19, "Issues with the Match, the National Residency Matching Program (NRMP)," introduced by the Indiana Delegation, asked the AMA to:

1. continue working to promote an increase in residency program positions in the U.S.;
2. study how residency programs can expand in novel ways;
3. determine what strategies can increase an applicant's ability to match into a residency program;
4. support the option of permitting those who failed to obtain a position during the Supplemental Offer and Acceptance Program® (SOAP®) in 2019 to participate in a future matching opportunity at no cost; and
5. encourage the National Resident Matching Program (NRMP) and the Electronic Residency Application Service (ERAS) to conduct an audit to identify opportunities for lowering the financial burden on applicants and to promote and disseminate strategies to mitigate issues that interfere with successfully matching. The full resolution is in the Appendix.

Online and in-person testimony during the 2019 Interim Meeting suggested that this resolution, which calls for a broad investigation into several different aspects of the resident match, has already been addressed in the recent past by the Council on Medical Education (CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students"). It was noted that the AMA has extensive policy on expanding graduate medical education (see for example D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"). Testimony also noted that the NRMP and the Association of American Medical Colleges (AAMC) release yearly authoritative reports on match outcomes with granular data for medical students to aid in their decision making. Others, however, expressed concern that current efforts to address this issue have been insufficient. The reference committee initially considered reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, but ultimately recommended referral of the entire resolution. The House of Delegates (HOD) subsequently agreed; this report is in response to that referral.

BACKGROUND

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to many resolutions presented to the AMA HOD and subsequent reports and policies generated to

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address those concerns. This report: a) summarizes the AMA's recent efforts to increase residency training positions and assist applicants in applying to residency programs; b) describes the technological problems of SOAP in 2019 and what has been done to prevent future problems; and c) describes resources for applicants on effective program application and matching.

AMA REPORTS, POLICY, AND ADVOCACY

The AMA Council on Medical Education (CME) has prepared several reports for the HOD addressing the process of matching into residency programs, as well as the need to increase funding for graduate medical education (GME). For example, CME Report 3-A-18, "Expanding UME Without Concurrent GME Expansion," included three recommendations that were adopted as policy and recorded in D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education:"

> (32) Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

CME Report 5-A-17, "Options for Unmatched Medical Students," outlined a number of key points related to unmatched medical students, including the long-term stability of match rates, common reasons for an unsuccessful match, options for students who do not match, and tools/initiatives from medical schools and medical organizations (including the AMA) to ensure an effective, efficient, and equitable match process that balances the interests of applicants and programs and promotes rational, strategic decision making by all parties. This report also highlighted AMA resources, including the AMA's Career Planning Resource, which includes guidance on applying for residency, choosing a specialty, interviewing for residency, writing a C.V., and finding residency programs through FREIDA™. Another tool described in this report is the AAMC's Careers in Medicine (CiM) online guide, which helps students make strategic decisions about residency training and beyond and provides self-assessment tools and specialty-specific data to inform those decisions.

CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," recommended reaffirming existing policy, namely D-305.967 (4) and (22), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education;" H-200.954 (4) (5) (6) and (7), "US Physician Shortage," and D-310.977 (11), "National Resident Matching Program Reform." These various policies direct the AMA to advocate for increasing GME positions; encourage research and data that support the value of GME; and encourage medical schools and residency programs to consider policies to attract physicians to practice in and care for patients in underserved and rural areas. Other policy encourages the AMA to work with other major stakeholders in medical education to evaluate data and propose new research that would describe how many students graduating from U.S. medical schools each year do not enter into a U.S. residency program; how many never enter into a U.S. residency program; whether there is

disproportionate impact on individuals of minoritized racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.

The AMA has long advocated for advancing GME, including increasing funding for residency positions, developing innovative funding models, and creating residency positions that reflect patient and societal needs. The AMA launched the Reimagining Residency Initiative in 2019 with $15 million in grants to projects promoting systemic change in GME. Recently the AMA offered technical assistance in the drafting of the Health Heroes 2020 Act (H.R. 6650), which proposes to bolster the National Health Service Corps (NHSC) by providing an additional $25 billion for both the loan repayment and scholarship programs to increase the number of medical professionals in underserved communities. The Act would also increase the mandatory NHSC funding level from $310M to $690M for fiscal years 2021-2026 to increase scholarship and loan forgiveness awards. The AMA offered assistance in the drafting of the Rural America Health Corps Act (S.2406) which builds upon the existing NHSC model by proposing up to five years of loan forgiveness (versus two) to help pay down medical school debt and increase the number of individuals that can enter the NHSC.

The AMA continues to voice its support for federal bills to increase residency positions, including the Resident Physician Shortage Reduction Act of 2021 (S. 834), which would expand Medicare funding for 15,000 additional residency positions. Earlier legislative proposals from 2019 that garnered AMA support and advocacy would close a loophole in GME cap-setting criteria affecting hospitals that temporarily host small numbers of residents (H.R. 1358), and provide 1,000 additional Medicare-supported GME positions over five years in hospitals that have, or are establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain management (H.R. 2439).

Most recently, there were multiple provisions in the new Appropriations Act that provide benefits for GME, variations of which AMA has advocated for, including:

- Increased funding ($310 million) from 2021-2023 for the National Health Service Corps, and extended funding through 2023 for teaching health centers that operate GME programs. (Sec. 301)
- Hospitals will be allowed to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a per resident amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)
- A thousand additional Medicare-funded GME residency positions (200 per year for 5 years), to be distributed to rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126)

TECHNOLOGICAL PROBLEMS FOR SOAP

SOAP is a joint service of the NRMP and ERAS. Through SOAP, qualified applicants who do not obtain a position through the NRMP Match are privy to a list of participating programs that did not fill all their positions through the Match. Applicants submit applications to programs of interest. Programs review the applications and select candidates to interview (via phone, video, or in-person

if local), and positions are then offered to successful applicants. This occurs over a compressed timeframe, with three rounds over two days.

In 2019 the ERAS system experienced technical issues during the SOAP process, which affected applicants and program directors. The system was taken offline to correct the problem, resulting in a shortened time frame to complete the process; therefore, the NRMP reduced the number of rounds from three to two. The AAMC conducted an internal root-cause analysis and had an external review completed by an industry expert to evaluate technology and processes. Those reviews identified immediate and long-term steps that were implemented to mitigate future risk and to improve systems and operations.[1] Similar technical issues also occurred during the first day of the SOAP process in 2021. The cause of these issues was not known at the time this report was prepared, but the AAMC has apologized for the situation and promised another thorough investigation to understand the poor performance and identify and implement solutions to improve the process. The Council on Medical Education will continue to monitor the situation.

Typically, around 600 U.S. MD seniors are without a position at the conclusion of SOAP. In 2019, there were 623 without a position versus 620 in 2018. In 2020, there were 522. Overall, all applicants accepted offers with roughly the same frequency: the percent of offers accepted was 64.1 in 2018, 62.5 in 2019, and 61.8 in 2020.[2,3,4] Data from the 2021 Match were not available at the time this report was prepared. Although the compressed schedule caused additional anxiety during a period that is normally stressful, the resulting proportions of applicants with positions are much the same. However, the NRMP has become concerned that in the past few years there has been a decrease in the number of SOAP-eligible applicants at the conclusion of the Match, compared to an increasing number of unfilled positions placed in SOAP, and an increasing number of unfilled positions at the end of SOAP. Coupled with the uncertainty surrounding the upcoming application and match season due to the COVID-19 pandemic, the NRMP has decided to add an additional, fourth offer round to the SOAP process.[5]

EFFECTIVE STRATEGIES FOR APPLYING AND MATCHING

The AAMC has numerous tools and informational guides developed to help students select a specialty and then apply to, interview with, and rank programs, all through the CiM website (https://www.aamc.org/cim/). Users of most CiM material need a subscription. Students of U.S. MD-granting schools have a subscription through their schools as a result of their school's membership in the AAMC. Students of DO-granting schools and international medical students may have subscriptions through their schools or may need to purchase an individual subscription for $75. Medical school advisers also have access to CiM material.

The AAMC launched the Apply Smart website in 2016 to assist students in determining the optimal number of residency programs to which they should apply. The website provides information on the relationship between the number of applications submitted and the likelihood of entry into a residency program, highlighting the point at which the likelihood does not increase as the number of applications increase. Apply Smart also provides ranges of United States Medical Licensing Examination® (USMLE®) Step 1 scores as a comparison metric and suggests that students should consider limiting their applications at the point of diminishing returns.[6] Although relatively easy to use and understand, there are some caveats to the tool's utility. The tool relies on USMLE 3-digit Step 1 scores, so students who do not have a Step 1 score, e.g., some students at DO-granting medical schools, will not find the tool useful. Future use of the tool when Step 1 results are reported as pass/fail (proposed to occur in January 2022) will also be in doubt, unless another valid metric is provided. Further, the tool's methodology has been questioned, in that the data uses the number of applications submitted through ERAS, which does not distinguish between

preferred specialties and backup specialties. Therefore, for example, a student may submit 10 applications to a specialty that is not the preferred one and ultimately choose not to enter it. This datapoint will contribute to a low likelihood of entering that specialty with only 10 applications.[7] One suggestion is to pair ERAS applications data with interviews offered data, which, with the support of residency programs, is available through ERAS, thus creating a probability that a given number of applications results in an interview offer. Also suggested is pairing ERAS application data with NRMP data, to filter preferred specialties from backup specialties.[7]

The AAMC has also developed the Residency Explorer tool, which uses Step 1 scores as well as Step 2CK and COMLEX-USA Level 1 and Level 2-CE scores. Offered free to U.S. medical and international students, Residency Explorer has benefited by creating a consortium of data providers. Users create a profile based on their test scores and academic achievements, and Residency Explorer will provide a list of programs in a chosen specialty with statistics on current and recent residents. Users can then compare where they stand in relation to matched residents at a given program. In addition, other characteristics about the program are provided for students to consider. Programs that have few residents or have been accredited for only a few years will not have test score information available and may also have few program characteristics to report. As with the Apply Smart tool, Step 1 three-digit scores will not be available once score reporting transitions to pass/fail; therefore, students of MD-granting schools will have one less metric.

The NRMP produces several reports that can be helpful in guiding applicants' decision-making. The "Results from the Program Director Survey" describes what factors are considered by program directors, as well as their importance, when deciding which applicants to interview, and then the same for deciding how to rank applicants. The report is broken down by specialty. Unfortunately, the response rate by program directors to this survey is low, averaging 18 percent in 2019.[8] Similarly, the NRMP surveys applicants and asks about the program characteristics that influenced both application and ranking choices as well as the relative importance of those characteristics. In the "Results of the 2019 NRMP Applicant Survey by Preferred Specialty and Applicant Type" report, applying, interviewing, and ranking behavior is available by whether the applicant successfully matched or not. These data are also available by specialty. This report has a response rate of 42.3 percent, and specialties with fewer than 50 respondents are excluded.[9]

More data on applicant characteristics and applying, interviewing, ranking, and matching success are available in the Charting Outcomes in the Match reports, available for U.S. MD seniors,[10] U.S. DO seniors,[11] and graduates of international medical schools (IMGs).[12] All data are self-reported, with the exception of match data. These reports are also segmented into specialties. In addition, the NRMP used 2018 match data to create an interactive tool, the Interactive Charting Outcomes in the Match, which allows users to enter their own values, such as number of publications, and assess the percentage of applicants who matched or did not match, by Step 1 or Level 1 score range.[13] Given the similarity to Residency Explorer, the NRMP has not further developed the interactive charts and collaborates with the AAMC on Residency Explorer.

The AMA provides general guidance offered by experts in the field on choosing a specialty and effective applying and matching strategies, most of which can be found on the AMA website ("The Match journey made simple," at https://www.ama-assn.org/residents-students/match/match-journey-made-simple). The AMA has also developed a new residency calculator tool to help students estimate the costs of applying to programs (https://freidaresidencycalculator.com/).

Aside from the AAMC and the AMA, other websites provide advice on residency program applications and interviews. Many of these are geared in particular to IMGs, but not always, and may charge a fee for assistance. Specialty societies also present information on program locations

and characteristics and advice on how to apply to programs in the specialty, such as family medicine (https://www.aafp.org/medical-school-residency/residency/process.html).

Finally, U.S. medical schools have dedicated staff that are eager to help students successfully match into residency programs, providing accessible online advice as well as personal counseling. The most commonly reported reason why a student does not successfully match is that the student's academic performance (e.g., clinical grades) and/or USMLE scores are below the norm for the desired specialty. Other commonly cited reasons are 1) applications in a single specialty, 2) lack of a backup plan, and 3) application to too few programs. These issues could be mitigated with advice, but some advisers report that some students do not make themselves available for career counseling.[14]

Pilots for 2021

The Otolaryngology Program Directors Organization, the Society of University Otolaryngologists, and the Association of Academic Departments in Otolaryngology created a voluntary signal preference program in advance of the 2021 match, modeled after the preference signaling program developed by the American Economic Association (AEA) to facilitate interview offers for economics graduate students. In the AEA model, students can send signals to up to two employers to indicate their interest in receiving an interview. Signals were found to increase probability of interviews, especially for niche scenarios (e.g., an applicant whose academic and personal background is limited to a single state or region may be viewed as unlikely to move to a different geographic region and therefore an interview may not be offered despite excellent qualifications of the applicant. A signal in this scenario changes the program's erroneous perception of applicant disinterest). The otolaryngology pilot allows applicants to signal up to 5 programs. The signals will be sent to participating programs around the time programs download applications from ERAS. Participating programs are advised to consider signals of interest as one factor in a holistic review of all applications and should not rely on signals to screen applications. In addition, programs should expect many non-signaled applications from interested and highly qualified applicants. Applicants were instructed not to signal their home institution or any programs at which they have completed a clinical subinternship in the current calendar year, and programs were advised not to expect to receive a signal from applicants in these scenarios.[15] Examining ERAS data does not suggest a reduction in the number of applications per applicant to otolaryngology programs compared to previous years.[16] It is not known publicly at this time how many programs and applicants participated in the pilot.

The Association of Professors of Gynecology and Obstetrics and the Council on Resident Education in Obstetrics and Gynecology have created the "Right Resident, Right Program, Ready Day One" pilot program for the obstetrics and gynecology specialty. The program received a $1.75M grant from the AMA's Reimagining Residency Initiative. Aspects of the program include a uniform application deadline date across all programs, limiting interview invitations to the number of interview slots available, allowing a minimum of 72 hours for applicants to respond to an interview invitation, and providing interview status (invited, waitlisted, or rejected) to all applicants by November 22, 2020.[17] In addition, the pilot program will develop an applicant compatibility index mobile device application that facilitates alignment between applicants' profiles and residency program offerings, and develop additional application review metrics for programs to use in screening. The goal is to increase transparency and efficiency in the process to reduce costs and anxiety and ultimately to increase individuals' success in training.[18]

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

Resolution 304-I-19 contained a wide variety of requests for action, including some in which the AMA is currently engaged. The AMA continues to advocate for an increase in GME positions, innovative models of GME training, and greater accountability overall in the funding for and outcomes of GME. The AMA has studied the causes of failures to match into a residency program—as have many medical education stakeholders—and has made resources available to students that can reduce the risk of failure (again, as have many medical education stakeholders). Other actions requested in the resolution are already reflected in material and tools prepared by the AAMC and NRMP. This information, however, is not all in one location. Furthermore, availability and ease of access to known successful strategies will not help applicants who do not avail themselves of advice that runs counter to their own sense of identity as a practitioner of a particular specialty.

Current proposals in the literature to improve the process of applying to, interviewing with, and matching to residency programs include, among many, signaling program preference in the application,[19] multi-phase matches,[20,21] and capping the number of applications so that each applicant can be considered more holistically.[22] The recent decisions of the Federation of State Medical Boards and the National Board of Medical Examiners, and the National Board of Osteopathic Medical Examiners, to report results of the USMLE Step 1 and the COMLEX-USA Level 1 examinations, respectively, as pass/fail rather than a three-digit score will remove metrics relied on by many individual program directors and application tools as a measure easily obtained and understood, although questionable in its ability to predict clinical performance. The application and interview season for the 2021 Match presented its own challenges, as programs were encouraged to interview applicants through video to reduce exposure to COVID-19. Few programs are experienced using virtual interviews, and most that have, have used them as adjunct to in-person interviews.[23] Programs were also encouraged to provide more information on the type of resident they are looking for, beyond academic statistics and overused adjectives. This is essential insight for students, who need to know when making their decisions to apply as to how well they would fit a given program.

Movement is afoot to revise the current system for program application, interviewing, and matching. In the interim, key stakeholder organizations, like the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information rationally if the desire is to successfully match to a program without unnecessary financial cost.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-I-19 and the remainder of this report be filed:

1. That our AMA reaffirm Policies D-310.977, “National Resident Matching Program Reform,” H-200.954, “US Physician Shortage,” and D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education.” (Reaffirm HOD Policy)

2. That our AMA encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency. (Directive to Take Action)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

D-310.977, "National Resident Matching Program Reform"

Our AMA:

(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

H-200.954, "US Physician Shortage"

Our AMA:

(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and

(c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)
Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice
(Resolution 308-I-19)
(Reference Committee C)

EXECUTIVE SUMMARY

International medical graduates (IMGs) currently represent a quarter of the physician workforce and physicians-in-training in the United States. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations, and their foreign language proficiency can be invaluable when communicating with patients from the same country of origin. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce. This diversity is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, which assures the quality of the medical workforce and protects the public. That said, some licensing regulations, such as attaining source documents to verify one's medical education or other schooling, may be more challenging for IMGs than for physicians who graduated from medical schools in the U.S. Improving and streamlining licensing and credentialing policies and processes, where appropriate, can ensure that IMGs can help address health care inequities and improve health care access through service in federally designated health care shortage areas.

The goal of this report, which is in response to American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," is to "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA."

This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas. This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. New models, such as those described in this report, may enable physicians to be credentialed and licensed in a more efficient and timely manner in an effort to address national or international pandemics or medical emergencies at a state or regional level. The Council on Medical Education believes that states remain best positioned to evaluate the relative success of these programs in addressing their needs. In addition, successful efforts to reduce medical licensing barriers should be shared as best practices across states.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-JUN-21

Subject:	Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (Resolution 308-I-19)
Presented by:	Liana Puscas, MD, MHS, Chair
Referred to:	Reference Committee C

American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," asks that our AMA "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA." This report is in response to that policy.

INTRODUCTION

There is a projected shortage of physicians in the United States, given the aging of the present physician and general civilian populations, as well as potential and ongoing crisis situations, such as the COVID-19 pandemic, which has spiked the need for patient care and hospital beds across the country.[1] Compared with U.S. medical school graduates, IMGs provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain states and specialties disproportionately depend on these physicians. IMGs represent nearly one-quarter of the U.S. physician workforce. They often practice at institutions that are on the front line of the COVID-19 pandemic, and these physicians play a critical role in providing health care in areas of the country with higher rates of poverty and chronic disease. Appendix A displays the U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state.

The continued steady influx of immigrants from strife-torn regions of the world to the U.S. includes highly trained physicians fleeing their country because of political or religious persecution. These immigrant physicians may have beneficial skills, such as professional experience and language proficiency. However, IMGs often face licensing barriers beyond those of physicians who graduated from a U.S. medical school. IMGs often are required to repeat complete cycles of training, including medical school, residency, and subspecialty training. This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas.

This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

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CREDENTIALING REQUIREMENTS

Certification by the Educational Commission for Foreign Medical Graduates (ECFMG) is the standard for evaluating the qualifications of IMGs before they enter U.S. residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG requirements include examinations in the medical sciences, evaluation of English language proficiency, and documentation of medical education credentials.[2]

Non-U.S. citizen IMGs who seek entry into U.S. graduate medical education (GME) programs must obtain a visa permitting clinical training to provide medical services. The ECFMG / Foundation for Advancement of International Medical Education and Research Exchange Visitor Sponsorship Program (EVSP) serves as the visa sponsor for approximately 12,000 IMGs at teaching hospitals in the U.S.[3-4] All non-U.S. citizen IMGs enter the U.S. in one of two broad immigration categories—either under a temporary, nonimmigrant visa or as a permanent resident. The two most common temporary, nonimmigrant classifications for IMGs are the J-1 Exchange Visitor program and the H-1B temporary worker classification. Both classifications limit a physician's duration of residence in the U.S. and impose strict controls over the range of employment authorized. In contrast, permanent residence provides a foreign national with both an unlimited duration of residence in the U.S. and authorization of full, unrestricted employment. However, the lead time required to qualify for permanent residence status is usually substantially longer than the lead time required to obtain temporary worker status.[4] Additional information about visa options for IMGs is provided in Appendix B.

Certification from the ECFMG is a requirement for medical licensing, and it is a prerequisite for taking the United States Medical Licensing Examination (USMLE) Step 3. However, state licensure requirements vary from state to state.[5] All state licensing jurisdictions require IMGs to complete at least one year of accredited U.S. or Canadian GME before licensure. However, 21 states require two years, and 27 states require three years of accredited GME.[5]

Some states issue limited, restricted licenses that allow IMGs who have not entered U.S. GME to practice in the U.S. under supervision and in specific institutions. To qualify, IMGs must have been trained in a specialty and practiced medicine abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution, despite being ineligible for full licensure. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about states that issue restricted licenses.)

Many institutions also require that physicians be board-certified or board eligible. However, it is the policy of the American Board of Medical Specialties (ABMS) that to be eligible for certification in any specialty or subspecialty and to maintain certification a physician must: 1) complete ACGME-accredited or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited GME; and 2) hold a full and unrestricted license to practice medicine in at least one jurisdiction in the U.S., its territories, or Canada. Some of the ABMS member boards recognize alternative pathways that may meet eligibility requirements for initial board certification for candidates who have not completed U.S. or Canadian-accredited GME.

Recognized alternative pathways for international trainees that may meet eligibility requirements include Canadian and international training. Twenty ABMS member boards accept all of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board) and of these, seven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada

(either accredited by the RCPSC or by another body acceptable to the board). Fifteen boards offer pathways for non-Canadian internationally trained physicians. Of these, nine boards offer pathways for physicians practicing in the U.S. at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor). Two boards will accept international training as meeting all training requirements on a case-by-case basis, and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about board certification pathways.)

On January 26, 2021, the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), co-sponsors of the USMLE, announced the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS) and henceforth the discontinuation of Step 2 CS, while continuing to seek innovative and sensible ways to assess medical licensing eligibility. ECFMG continues to oversee requirements for its certification of IMGs and announced an expansion of its pathways allowing qualified IMGs to meet the requirements for ECFMG Certification and continue to pursue U.S. graduate medical education.

AMA ADVOCACY ACTIVITIES DURING COVID-19 RELATED TO IMGS

The AMA has been especially active in its federal level advocacy efforts on behalf of IMG physicians during the COVID-19 pandemic. Some of the areas in which AMA advocacy has been most significant include visas, labor condition applications, work surrounding last year's presidential proclamations, and the HEROES Act.

Visa Processing, Allocation, and Extensions

On March 20, 2020, U.S. Citizenship and Immigration Services (USCIS) suspended premium processing for visas. As such, IMG physicians were concerned about being able to obtain visas in a timely manner. In response, on March 24, 2020, the AMA sent a letter to USCIS urging USCIS to reconsider the suspension and instead expand premium processing for H-1B visas. USCIS reopened its offices and resumed citizenship ceremonies in June 2020. Additionally, it restarted premium processing for certain visa petitions, including H-1B visas, in phases throughout June. Moreover, companies were allowed request accelerated processing for immigrant worker visas, and employers who had pending H-1B temporary worker visas could ask for their applications to be fast-tracked. Per the USCIS website, premium processing for H-1B visa holders is available.

As the severity of the COVID-19 pandemic increased, embassies and consulates around the world stopped processing visas, including J-1 physician visas. As such, J-1 physicians were concerned that they would not be able to obtain or maintain a valid visa. Additionally, due to visa restrictions, J-1 physicians were concerned about being able to continue their training during the pandemic. In response, the AMA sent a letter to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting opening of visa processing at embassies and consulates for physicians joining U.S. residency programs on July 1, 2020. Additionally, the AMA requested that J-1 physicians be allowed to engage in extended training activities and asked for confirmation concerning J-1 physician redeployment to new rotations to respond to the pandemic. As a result of AMA advocacy, in concert with ECFMG, the DoS agreed to begin processing visa applications for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor to extend their programs in the U.S. The AMA also confirmed that J-1 physicians can engage in revised clinical training rotations/assignments, in keeping with the ACGME's "Response to Pandemic Crisis."

IMG physicians were also concerned about alterations in work schedules and the visa consequences of being laid off due to the impact of the COVID-19 pandemic. To help ease these concerns, on April 14, 2020, the AMA sent a letter urging USCIS to recognize the COVID-19 pandemic as an extraordinary circumstance beyond the control of non-U.S. citizen IMG applicants or their employers. The AMA consequently asked to expedite approvals of extensions and changes of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In addition, the AMA urged the Administration to extend the 60-day maximum grace period to a 180-day grace period to allow any non-U.S. citizen IMG who had been furloughed or laid off as a result of the pandemic to remain in the U.S. and find new employment. Moreover, the AMA asked USCIS to protect the spouses and dependent children of H-1B physicians by automatically granting a one-year extension of their H-4 visas. Due in part to the advocacy efforts of the AMA, USCIS announced that it is temporarily waiving certain immigration consequences for failing to meet the full-time work requirement due to quarantine, illness, travel restrictions, or other consequences of the pandemic.

Throughout the pandemic, the AMA has not lost sight of the need for long term policy change, especially change surrounding the need for an increase in visas for additional physicians. As such, on May 8, 2020, the AMA sent letters to the U.S. House of Representatives and the U.S. Senate supporting the "Healthcare Workforce Resilience Act" and urging the Congress to quickly pass the legislation so that the U.S. can recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years. The bill was not enacted.

Labor Condition Applications

Labor Condition Application restrictions have made it difficult for IMGs to practice in areas where they are most needed during the pandemic. As such, on April 3, 2020, the AMA wrote a letter to then Vice President Pence and USCIS urging the Administration to permit non-citizen IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition to apply and quickly receive authorization to work at multiple locations and facilities, with a broader range of medical services, for the duration of the COVID-19 pandemic. The AMA also urged the Administration to expedite work permits and renewal applications for all IMG physicians who are beginning their residencies or fellowships or are currently in training. Due in part to the advocacy efforts of the AMA, USCIS announced that IMGs can deliver telehealth services during the current public health emergency without having to apply for a new or amended Labor Condition Application. At the time of the writing of this report, the AMA is not planning additional follow up on the Labor Condition Application.

Presidential Proclamation

As a result of the April 22, 2020 Presidential Proclamation, *Suspending Entry of Immigrants Who Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19 Outbreak*, the AMA sent a letter to then-Vice President Pence urging the Administration to allow IMGs with J-1, H-1B, and O-1 (individuals with extraordinary ability or achievement) visas to be exempt from any future immigration bans or limitations, so that these physicians can maintain their lawful non-immigrant status while responding to the pandemic.

On June 22, 2020, President Trump issued a Proclamation, *Suspending Entry of Aliens Who Present a Risk to the U.S. Labor Market Following the Coronavirus Outbreak*. In response to the proclamation, the DoS issued a statement that "as resources allow, embassies and consulates may continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa categories include applicants who may be eligible for an exception under these presidential

proclamations, such as…certain medical professionals." As such, on June 26, 2020, the AMA sent a letter to the DHS and the DoS strongly urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country, so that families could remain together and IMG physicians could immediately begin to provide health care services to U.S. patients. The AMA understands that every physician is mission-critical, especially at this time.

Moreover, on July 8, 2020, the AMA initiated a sign-on letter for medical specialty societies. The letter urges the DoS and DHS to issue clarifying guidance pertaining to the June 22, 2020, proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest.

During his first day in office, President Biden issued a *Proclamation on Ending Discriminatory Bans on Entry to The United States* to revoke Executive Order 13780 of March 6, 2017 (Protecting the Nation From Foreign Terrorist Entry Into the United States), Proclamation 9645 of September 24, 2017 (Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), Proclamation 9723 of April 10, 2018 (Maintaining Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), and Proclamation 9983 of January 31, 2020 (Improving Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats).

On January 25, 2021, President Biden issued a *Proclamation on the Suspension of Entry as Immigrants and Non-Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease* to further examine certain current public health precautions for international travel and take additional appropriate regulatory action, to the extent feasible and consistent with Centers for Disease Control and Prevention guidelines and applicable law.

HEROES Act

H.R. 6800, the "Health and Economic Recovery Omnibus Emergency Solutions Act" (HEROES ACT), is the U.S. House of Representatives' next proposed coronavirus relief fund package and incorporates many of the IMG advocacy requests, including authorization of the Conrad 30 Program, expedited visa processing, and employment authorization cards for IMGs. For more information, see sections 191201 and 191204 of the HEROES Act or the AMA HEROES Act Summary. The AMA has worked with members of the U.S. House of Representatives to help ensure that favorable measures for IMGs are included in this proposed legislation. At the time of the writing of this Council report, the HEROES ACT had been passed in the House and was sent to the Senate. It was assigned to the Committee on Small Business and Entrepreneurship and hearings were held but no action was taken. The Continuing Appropriations Act (H.R. 8337) was passed; however, it had very little in it concerning IMGs. The most recent stimulus bill, the American Rescue Plan, does not include anything related to IMGs.

Additional Rule Changes

In the latter part of 2020, the AMA commented on related rule changes/proposed rule changes. Information regarding these rules and comments are located in Appendix C.

IMG Resource Guide

Due to the uncertainty that IMGs are experiencing during this time, the AMA has created an IMG resource guide, "FAQs: Guidance for international medical graduates during COVID-19." This guide answers some of the most pressing questions IMGs have surrounding their ability to practice and visas. It also lists available resources for assistance.

REVISIONS TO STATE LICENSURE REQUIREMENTS DURING COVID-19

In areas where physicians were acutely needed to address the needs of the patient surges during the pandemic, state agencies created stratification processes for those non-U.S. citizen IMG physicians most easily integrated into the system. These were IMGs working under direct supervision of licensed physicians and identified on the basis of education, training, certification as a medical specialist, English proficiency, and experience in direct patient care in countries other than the U.S. For example, in 2020 the New Jersey Division of Consumer Affairs had been authorized to issue temporary state medical licenses to IMGs who are licensed and in good standing in other countries, along with other workforce measures. In January 2021, it was announced they were no longer accepting new applications and pending applications were put on hold per review of the program.[6] In New York, a March 23, 2020 executive order from Governor Cuomo allows non-US citizen IMGs who are not licensed in the state but have completed at least one year of GME in the U.S., to provide patient care in hospitals, under the supervision of a New York State-licensed and registered physician, by way of a limited permit. This order was extended until May 6, 2021.[7-8]

PROGRAMS THAT SERVE AS MODELS FOR ACCELERATED TRAINING AND CREDENTIALING

Programs such as the National Health Service (NHS) of Scotland show it is possible to retrain immigrant physicians in 18 to 24 months, and that these physicians are able to demonstrate proficiency in language, medicine, and the culture of the host country. Immigrant physicians in Scotland who have been retrained on an accelerated path and who have demonstrated proficiency in language, medicine, and Scottish culture are obligated by the NHS of Scotland to practice in the NHS specific areas of need.[9]

Similarly, the following states are studying and developing pathways for qualified IMGs to expeditiously enter practice in the U.S.

Minnesota

The Minnesota Department of Health (MDH) has supported the integration of IMGs through the state's International Medical Graduate Assistance Program.[10] As the first program of its kind in the U.S., the Minnesota Legislature established this program in 2015 to address barriers to practice and facilitate pathways for immigrant IMGs to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. It has achieved considerable success, including forming grant agreements with nonprofits to provide career support to IMGs and working with residency directors to carve out pathways for IMGs to demonstrate the clinical expertise required to enter into residency programs. The program requires that participants be legal residents who have lived in Minnesota for at least two years, graduated from an accredited medical school outside the U.S., and are willing to practice primary care in the state's underserved communities in rural and urban areas.

In its 2018 report, the MDH reported that the program has developed a database comprised of immigrant IMG physicians in Minnesota. The program also identified barriers to residency, and it is taking steps to address those barriers with the following interventions: funding dedicated residency positions for immigrant IMGs, supporting clinical readiness assessment and preparation programs, and providing career guidance and support. The MDH report includes data on IMGs who received career guidance and support as well as those who were selected by the University of Minnesota Medical School to participate in the clinical experience component, which began in September 2017.

The MDH met with the Minnesota Board of Medical Practice and other stakeholders to study possible changes to the Medical Practice Act. The group proposed two possible strategies: an IMG Primary Care Integration License and an amendment to the Medical Practice Act, which would include an exemption for practicing primary care in a rural or underserved area. As noted in the 2018 MDH report, the creation of this alternate license would be beneficial because it would allow objectively qualified IMGs into the system quickly to address issues of health disparities and primary care shortages. It would not require additional residency positions and thus would be cost-effective. The process would require that IMGs pass all licensure exams, demonstrate previous work of at least seven years in medical practice, participate in a six-month clinical experience, and undergo an assessment. This process would culminate in a certificate allowing work under supervision.

Implementation of this proposal raised several concerns. This effort is based on identifying and securing the commitment of an accredited assessor. In addition, these IMGs would not be eligible for board certification and may encounter employment restrictions. Key stakeholders, including the Minnesota Medical Association and Minnesota Academy of Physician Assistants, have raised objections, citing concerns over a tiered licensure system and professional role confusion. The MDH continues to research possible licensure changes.[11-13]

THE CONRAD 30 J-1 VISA WAIVER

IMGs who graduate from U.S. residency and fellowship programs may be in search of hospitals and practice groups that will support them in continuing their careers in the U.S. If these physicians held a J-1 Exchange Visitor visa during their GME in the U.S., they are required to return to their home countries for a two-year period before they can continue their careers in the U.S., but this provision can be waived in specific instances. One common way to do so is through the Conrad 30 Program, whereby a hospital or health center makes an application to a state department of health, requesting that the two-year home residency requirement be waived in exchange for the physician's three years of service in a medically underserved or health professional shortage area. The program currently allows for 30 waivers per state per year. However, the details of this annual program differ by state. States collectively recruit approximately 800 to 1,000 IMGs annually through the Conrad 30 program to practice in underserved communities.[17]

A study conducted by the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center, University of Washington, showed that Conrad 30 program staff generally valued the J-1 visa waiver as one of several important tools for recruitment of physicians to rural and underserved communities.[17] Since at least 2013, there have been efforts to make the Conrad 30 J-1 visa waiver program for physicians permanent; as this has yet to occur, it has been necessary to reauthorize the program every year. In 2019, bill was introduced in Congress to improve and extend the program until 2021—*the Conrad State 30 and Physician Access Reauthorization Act*.[18] The bill was not enacted.

The AMA has been vocal in its support for the Conrad 30 program over the years. Recently, the AMA worked with U.S. Senator Amy Klobuchar and a bipartisan list of other U.S. Senators to show the impact of the Administration's immigration policy changes during the pandemic to IMGs, reiterating the value of the Conrad 30 program and the need for its reauthorization.

RELEVANT AMA POLICY

The AMA has extensive policy regarding the requirements to practice medicine in the United States. AMA Policy H-255.983 states that "the AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character." Policy H-275.934 (2) states, "All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine." Policy H-255.966 (1.D.) notes, "U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions." Policy H-255.985 (1) states, "Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States programs." Policy H-255.988 states that the AMA "continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs."

At the Special Meeting of the AMA House of Delegates in November 2020, Policy D-275.950 "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association" was adopted. In part it asks that the AMA "in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency." Other related policies are shown in Appendix D.

SUMMARY AND RECOMMENDATIONS

IMGs currently represent a quarter of the physician workforce and physicians-in-training. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce.[19] This is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, but some licensing regulations may be more challenging for IMGs than for U.S.-educated physicians. There are, however, ways to improve and streamline licensing and credentialing policies and processes to ensure that IMGs can be recruited to federally designated health care shortage areas to address health care inequities and improve health care access. The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. Proposed and enacted state models, such as those described in this report, may enable physicians to be quickly credentialed and licensed in an effort to address national or international pandemics or state/

regional medical emergencies. States remain best positioned to evaluate the relative success of these programs in addressing their needs; however successful efforts to reduce medical licensing barriers should be shared among state licensing boards as best practices.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That American Medical Association (AMA) Policy D-255.980 (1), "Impact of Immigration Barriers on the Nation's Health," that reads, "Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine" be reaffirmed. (Reaffirm HOD Policy)

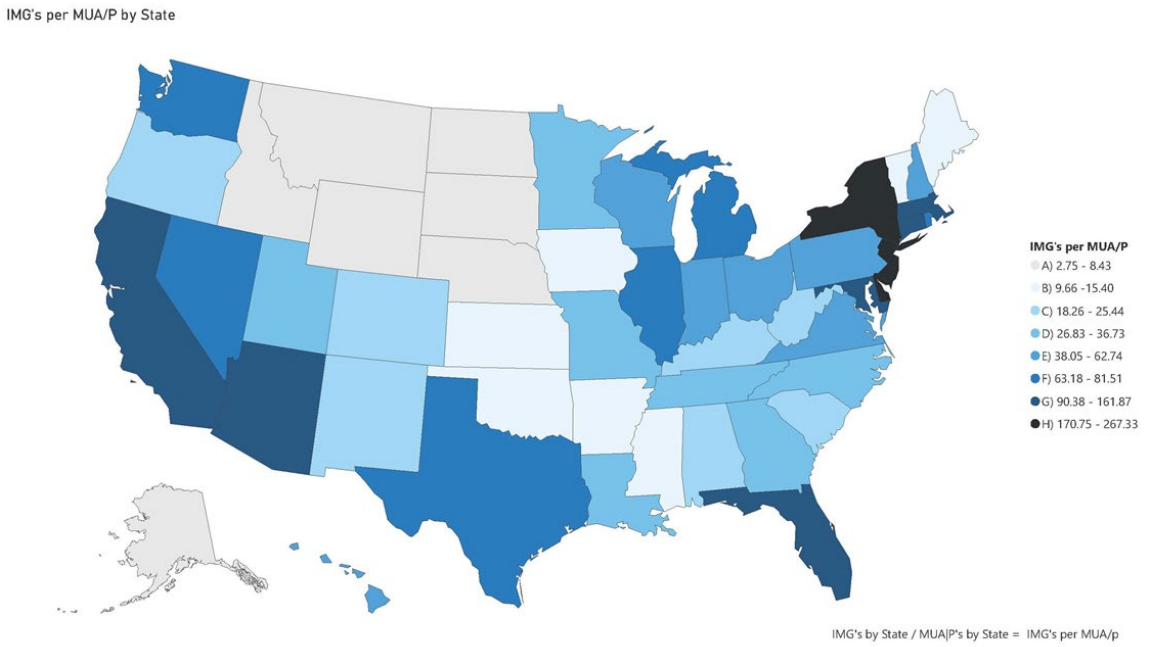
2. That our AMA encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas. (Directive to Take Action)

3. That our AMA encourage the Federation of State Medical Boards and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation. (Directive to Take Action)

4. That Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to US Medical Practice," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal Note: $1,000.

Appendix A. U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state



Data sources;
Health Resources & Services Administration (HRSA), Medically Underserved Areas/Populations (MUA/P) data: 2021. Available at: https://data.hrsa.gov/maps/map-tool/. Accessed 1-14-21.
Association of American Medical Colleges (AAMC), 2019 State Physician Workforce Data Report. Available at: https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report. Accessed 1-12-21.

Map created with Microsoft Power BI.

Appendix B. Visa Options for Non-U.S. Citizen International Medical Graduate Physicians

Visa Option	Purpose	Requirements
J-1 Exchange Visitor program[1-2]	Intended to provide a broad range of foreign nationals with educational, employment, and training opportunities in the U.S. Allows International Medical Graduate (IMG) physicians to attend residency and fellowship programs in the U.S. *Physicians wishing to stay in the U.S. after completion of training (or applying for a Green Card), must first return to their home country for a period of two years.*	Educational Commission for Foreign Medical Graduates (ECFMG) Certification* including: 1. Passage of United States Medical Licensing Examination (USMLE) Steps 1 and 2 examinations or the Visa Qualifying Examination (VQE) prepared by the National Board of Medical Examiners, and administered by the ECFMG to establish medical competence 2. Passage of the ECFMG English language examination 3. Possession of an MD degree** from a foreign medical school listed in the International Medical Education Directory of the Foundation for Advancement of International Medical Education and Research (FAIMER®) A statement of need from the government of the country of the physician's nationality or last legal permanent residence to provide written assurance to the Secretary of Health and Human Services of the need in that country for persons with the skills the physician seeks to acquire and that the physician has filed a written assurance with the government of this country that he/she will return upon completion of the training An agreement or contract from a U.S. accredited medical school, an affiliated hospital, or a scientific institution to provide the accredited graduate medical education (GME), signed by the physician and the official responsible for the training *Upon entry to the U.S., an IMG is authorized to pursue GME training for a period of up to seven years. Each year, the training program in conjunction with the IMG must file an extension application with the ECFMG.*
J-1 Waiver[3]	Can be granted for the J-1 two-year requirement. *The most common waiver options are those granted by: 1) obtaining an official recommendation from an interested government agency in need of the physician's services, or 2) through the*	Grounds under law to obtain a waiver of home residence obligation: • If the physician will suffer from persecution in his/her home country or country of last permanent residence • If fulfillment of the two-year home residence obligation will subject a U.S.

	Conrad 30 Waiver Program offered by states in exchange for three years of service in a qualifying medically underserved area.	citizen spouse or child to exceptional hardship • Based on a recommendation issued by a government agency interested in the physician's continued residence or employment in the U.S.
H-1B Temporary Worker classification[4]	Enables a foreign national to enter the U.S. to accept professional level employment for a period of up to six years. *IMG physicians must have an existing job offer for full-time employment with a U.S. employer. This can be a hospital, university, clinic, a doctor's office, or an assisted living community.*	A certified Labor Condition Application covering each location where the physician will perform services as required under Department of Labor regulations Completion of a medical degree from either a U.S. based school or an acceptable school in a foreign country Possession of a full, unrestricted state medical license or the "appropriate authorization" for the position Completion of the USMLE (Steps I, II, and III) or be eligible for the limited exceptions to this requirement English language competence as established through graduation from an accredited medical school or by passing the ECFMG English language examination
O-1 Visa: Individuals with Extraordinary Ability or Achievement[5]	Option for well-established doctors who are looking to come to the U.S. to practice. *Significant amount of documentation needed to qualify*	Must demonstrate (through awards, publications, or other evidence) extraordinary accomplishments in the medical field The position for which the physician is going to work must require someone with well-above average skills and experience Abilities must be corroborated with consultation letters (detailed letters of recommendation) from other respected experts in the applicant's specific field May be exempted from the USMLE examination requirement (some state medical boards may still require USMLE passage)

*All IMGs, regardless of country of citizenship, are required to complete ECFMG Certification to be eligible for J-1 visa sponsorship for clinical GME in the U.S. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. U.S. and Canadian citizens who graduate from medical schools located outside the U.S. and Canada are considered IMGs and must be certified by ECFMG.[1]

**The ECFMG Reference Guide for Medical Education Credentials lists the exact name of the final medical diploma that these applicants must have earned (and must provide).

1. Exchange Visitor Sponsorship Program (EVSP). Educational Commission for Foreign Medical Graduates. Available at: https://www.ecfmg.org/evsp/ (Accessed 7-20-20).
2. Exchange Visitor Program. U.S. Department of State. Available at: https://j1visa.state.gov/programs (Accessed 7-16-20).
3. Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement. U.S. Department of State-Bureau of Consular Affairs. Available at: https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html (Accessed 7-20-20).
4. H-1B Specialty Occupations, DOD Cooperative Research and Development Project Workers, and Fashion Models. U.S. Citizenship and Immigration Services. Available at: https://www.uscis.gov/working-united-states/temporary-workers/h-1b-specialty-occupations-dod-cooperative-research-and-development-project-workers-and-fashion-models (Accessed 7-16-20).
5. O-1 Visa: Individuals with Extraordinary Ability or Achievement. U.S. Citizenship and Immigration Services. Available at: https://www.uscis.gov/working-united-states/temporary-workers/o-1-visa-individuals-extraordinary-ability-or-achievement (Accessed 7-20-20).

Appendix C. Rule Changes/ Proposed Rule Changes

J-1's

- In October 2020, the U.S. Department of Homeland Security (DHS) released a proposed rule titled "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media." The proposed administrative change to eliminate "duration of status" as an authorized period of stay would significantly disrupt the medical specialty and subspecialty training of thousands of foreign national physicians in the United States in J-1 visa status, which in turn will have severe implications for patient care.
- DHS is proposing to eliminate the duration of status in favor of only admitting J-1 physicians until the program end date noted in their Form I-20 or DS-2019, not to exceed four years, unless they are subject to a more limited two-year admission, plus a period of 30 days following their program end date. Individuals who need time beyond their period of admission would have to timely file a complete extension of stay (EOS) with U.S. Citizenship and Immigration Services (USCIS) before their prior admission expires. As such, under the proposed rule, J-1 physicians applying for EOS would need to file a Form I-539 with the required fee, provide biometrics, and possibly undergo an interview. While the rule provides an admission period of two to four years, this timeframe will not be applicable to J-1 physicians because they are required to undergo an annual application process.
    - On October 23, 2020, the AMA commented on a DHS proposed rule concerning "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media."
    - The AMA urged DHS to withdraw the proposed rule as it relates to J-1 IMGs.
    - The AMA signed onto two letters, one that was circulated around the Hill and one that was submitted as a formal comment that asked that IMGs be exempt from the proposed rule.
    - The AMA spearheaded a letter that was sent by Representatives Brad Schneider (D-IL), Abby Finkenauer (D-IA), and David McKinley (R-WV) to the Department of Homeland Security (DHS) in opposition to the regulatory changes to duration of status for J-1 physicians. The letter also opposes the regulation because it will disrupt the Conrad 30 Program. The letter was co-signed by 36 bipartisan members of Congress and sent to DHS' Legislative Affairs Department.

H-1B's

- The AMA drafted a letter in opposition to the interim final rule "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States." In the letter the AMA strongly urged the U.S. Department of Labor (DOL) to rescind the Interim Final Rule (IFR), effective October 8, 2020. If rescission is not possible, we urged the DOL to exempt physicians from the IFR. Additionally, the AMA strongly urged the DOL to continue to approve, and DHS to annually accept, without reservation, the wage data from the Association of American Medical Colleges (AAMC) Survey of Resident/Fellow Stipends and Benefits Report for our foreign medical residents.
    - Currently, the Immigration and Nationality Act (INA) requires employers attempting to hire H-1B physicians to pay the greater of "the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question," or "the prevailing wage level for the occupational classification in the area of employment." Without providing evidence-based reasoning, this rule increased wage levels. Specifically,

the entry level wage (Level 1) was increased from representing the 17th wage percentile or higher than 17 percent of all wages for that specific position in that Metropolitan Statistical Area, to representing the 45th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 62nd percentile, Level 3 (experienced) from the 50th percentile to the 78th percentile, and Level 4 (fully competent) from the 67th percentile to the 95th percentile.
    - Recently ruled to be in violation of the Administrative Procedure Act by a District Court.
    - Implementation date has been delayed. Comment period has been reopened until April 21, 2021. Rescindment of rule also under consideration.
- The AMA commented on proposed rule "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions."
    - DHS proposed to amend its regulations governing the process by which U.S. Citizenship and Immigration Services (USCIS) selects H-1B registrations for filing of H-1B cap-subject petitions (or H-1B petitions for any year in which the registration requirement will be suspended), by generally first selecting registrations based on the highest Occupational Employment Statistics (OES) prevailing wage level that the proffered wage equals or exceeds for the relevant Standard Occupational Classification (SOC) code and area(s) of intended employment.
    - On December 2, 2020, the AMA submitted comments strongly opposing the DHS proposed rule "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions." This proposed rule seeks to abruptly and unnecessarily change the selection process for H-1B cap-subject petitions by prioritizing registrants based on the highest prevailing wage or highest proffered wage. In our comments, we acknowledge that it is false to assume that higher skilled workers are always paid a higher wage and thus, this conclusion made by DHS devalues physicians practicing in medically underserved areas. AMA strongly urged DHS to withdraw the proposed rule, but if withdrawal is not possible, DHS was urged to exempt physicians from this provision.
    - It was scheduled to go into effect March 9, 2021 but has been delayed until December 31, 2021
- The AMA commented on proposed rule "Strengthening the H-1B Nonimmigrant Visa Classification Program."
    - DHS is proposing to revise the regulatory definition of and standards for a "specialty occupation."
    - On December 4, 2020, the AMA submitted comments. The United States District Court of the Northern District of California ruled on December 1, 2020 that the IFR is in violation of the Administrative Procedures Act. For the reasons stated in the court's ruling, we agree. The AMA strongly urges DHS to rescind the IFR. If this, or a similar rule is implemented in the future, DHS was urged to exempt physicians.

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Appendix D: Relevant Policy

D-255.978, Study Expediting Entry of Qualified IMG Physicians to US Medical Practice
Our AMA will study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.
(Res. 308, I-19)

H-255.983, Graduates of Non-United States Medical Schools
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.
(Sub. Res. 45, A-88 Reaffirmed by Res. 311, A-96 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 7, A-04 Reaffirmed: Sub. Res. 314, A-04 Reaffirmed: CME Rep. 11, A-10 Reaffirmed: BOT Rep. 25, A-15)

H-275.934, Alternatives to the Federation of State Medical Boards Recommendations on Licensure
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
(CME Rep. 8, A-99 Reaffirmed: CME Rep. 4, I-01 Reaffirmed: CME Rep. 2, A-11 Modified: CME Rep. 2, A-12)

H-255.966, Abolish Discrimination in Licensure of IMGs
Medical Licensure of International Medical Graduates
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
(BOT Rep. 25, A-15)

H-255.985, Graduates of Foreign Health Professional Schools
(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.
(BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 320 and Res. 305, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 2, A-13)

H-255.988, AMA Principles on International Medical Graduates
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19)

D-275.989, Credentialing Issues
1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.
2. Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials.
(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11)

D-255.991, Visa Complications for IMGs in GME
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
(Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19)

D-255.985, Conrad 30 - J-1 Visa Waivers
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
(Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11 Modified: BOT Rep. 5, I-12 Appended: BOT Rep. 27, A-13 Reaffirmation A-14)

D-255.980, Impact of Immigration Barriers on the Nation's Health
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
(Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19)

H-200.972, Primary Care Physicians in Underserved Areas

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.
(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.
(CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19)

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REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)
Promising Practices Among Pathway Programs to Increase Diversity in Medicine
(Reference Committee C)

EXECUTIVE SUMMARY

In the early 1960s, cross-sectional efforts began to support increased diversification of the medical workforce through "pipeline programs" in response to a projected nationwide shortage of physicians. The shortage of physicians who are underrepresented in medicine (URM) was a consequence of structural factors that contributed to the marginalization of Black, Hispanic/Latinx, and Indigenous people, including exclusion from participation in medical education and careers in medicine. Legislative efforts such as Title VII programs were a means to improve the maldistribution of physicians and other health professionals and to improve the racial and ethnic diversity of the health care workforce. The two Title VII pipeline programs with the largest impact on enrollment of historically underrepresented groups in medicine are the Health Career Opportunity Program (HCOP) and the Centers of Excellence (COE). Over time, the term pipeline evolved to "pathway" to reflect the multiple paths to a career in medicine and to move away from the negative connotation associated with "pipeline." These pathway programs have provided opportunities to support the increase of racial, ethnic, gender, and socioeconomic diversity of the medical workforce. In addition to these public programs, there are numerous private pathway programs across the continuum of medical education to support diversity in medicine and access to care for the underserved.

Although there is limited evidence on the effectiveness of pathway programs, high quality studies suggest that interventions such as targeted recruitment and revised admissions policies; curriculum changes; summer enrichment programs; and comprehensive programs that integrate multiple interventions, such as financial, academic, and social support, can exert a meaningful, positive effect on student outcomes and increase diversity across various levels of educational settings.

The success of "pathway programs" has been hindered by anti-affirmative action initiatives; inconsistent funding for Title VII programs; disparities in the development of an adequate applicant pool for medical school admissions; disparities in the admissions, recruitment, and retention rates for historically underrepresented groups in medical education and medicine; and negative social integration into the campus, training, and work environment. Efforts to make the medical workforce more reflective of the nation's diversity will have to address multiple factors along the continuum of the education system and professional development. Additionally, it should be noted that oppressive structures, policies, and culture are perpetuated in various forms today and new pathway programs have emerged to expand gender equity among specific specialties such as radiology, orthopaedic surgery, and obstetrics/gynecology.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-JUN-21

Subject: Promising Practices Among Pathway Programs to Increase Diversity in Medicine

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

AMA Policy D-200.985 (13), "Strategies for Enhancing Diversity in the Physician Workforce," asks that the AMA (a) support the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs, and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

The Council on Medical Education offers this report to provide an overview of interventions used by "pathway programs" based on targeted milestones along the journey to becoming a physician; to identify institutional and structural factors that interfere with or create attrition on the journey; and to discuss recommendations to minimize interference/attrition on the journey to becoming a physician.

DEFINITION OF PIPELINE/PATHWAY PROGRAMS IN MEDICINE

Historically, the term "pipeline" in medical education has been used as a metaphor to describe the progression of individuals from one level of medical education to the next.[1] However, it should be noted that use of this term has been criticized as the model erroneously presents a series of invariant steps necessary to pursue a career in medicine. This rigid and reductionist approach can have an especially negative impact on women and underrepresented groups in their pursuit of medical careers.[2] More recently the adoption of the term "pathway" has gained favor as it symbolizes a more flexible and less restrictive course that individuals can take on their path to becoming physicians. For the purposes of this report, the term "pathway programs" will be used to describe the progression of individuals from one level of medical education to the next. The pathway therefore begins as early as prekindergarten and extends through college, medical school, graduate medical education (GME), and up to faculty development. Pathway programs are designed to assist individuals, particularly those who have been historically underrepresented in medicine (URM), to envision a career in medicine and successfully transition from any one stage of education to the next with the goal of bolstering care for historically marginalized and minoritized patients. Some of the ways that pathway programs support learners include providing supplemental academic enrichment programs, experiential learning in medical/clinical settings, research experience, career/college counseling, standardized exam preparation, and mentorship.

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Given that health inequities are identified in all areas, URM individuals can be expected to enhance outcomes in any clinical discipline and deserve the opportunity for a rewarding career in medicine. The rationale for encouraging the creation of programs to enhance medical student diversity is that racial and ethnic diversity among health professionals has been shown to promote better access to health care, improve health care quality for underserved populations, and better meet the health care needs of an increasingly diverse population.[3] While it is a duty of all physicians to aid serving the underserved and support primary care, URM physicians have been found to be more likely to work in underserved areas and thereby increase access to health care for historically marginalized and minoritized patients. Additionally, diverse learners add value to medical education and research environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.[4,5]

HISTORY OF THE CREATION OF PATHWAY PROGRAMS IN THE UNITED STATES

For the first two-thirds of the twentieth century, U.S. medical schools were de facto segregated, since few medical schools would admit Black students. In 1900, Black students who aspired to have a career in medicine could only choose from 10 schools in the U.S.[6] Following the establishment of the Council on Medical Education in 1904, the Council adopted an "ideal standard" that medical schools ought to require preliminary education sufficient to enable the candidate to enter a recognized university; a five-year medical course; and a sixth year as an intern in the hospital. In 1906, the Council was tasked with rating medical schools and surveyed 160 schools regarding performance of graduates on state licensure examinations. The schools were graded as "acceptable," "doubtful," or "nonacceptable" based on a set of 10 defined qualifications. Only 82 schools receive an "acceptable" rating. The Council partnered with the Carnegie Foundation in 1909 to conduct a follow up study, entitled "Medical Education in the United States and Canada, a Report to the Carnegie Foundation for the Advancement of Teaching," which was known as the Flexner Report of 1910.

The Flexner Report of 1910, which shaped medical education in the subsequent century, alleged support of medical education at the historically Black colleges and universities to provide a physician workforce that would serve Black Americans, yet its recommendations resulted in the closure of 89 medical schools, including five of the remaining seven medical schools that trained Black physicians, due to these schools' inability to meet the standards set at the time.[7] The report also went beyond describing the substandard conditions at medical schools; it prescribed a limited role for Black physicians in their practices and hinted that Black physicians possessed less potential and ability than their white counterparts. Among his other findings, Flexner concluded that "educating the [Black] race to know and to practice fundamental hygienic principles" fell naturally to the Black doctor. Thus, "a well-taught negro sanitarian will be immensely useful." Flexner not only limited the role of African American physicians to caring for other African Americans but further restricted Black doctors to matters of public health.[8] While he viewed both Meharry Medical College and Howard University as being suitable for training Black physicians, he recommended divestment from the five underperforming institutions serving Black medical students and reallocation of those resources to Meharry Medical College in Nashville, Tennessee, and Howard University Medical Department in Washington, DC.

As recently as 1964, 93 percent of all medical students in the United States were men and 97 percent of those students were non-Hispanic white. Of the remaining three percent of medical students, all but a few were enrolled in Howard University and Meharry Medical College. At that time, less than 0.2 percent of all medical students were Mexican American, Puerto Rican, American Indian, or Alaska Native. Prevailing societal values and practices within the profession were reflected in restricted opportunities for URM medical school graduates to participate in

specialty training, medical society membership, hospital staff membership, and other professional activities.[7]

Beginning in the early 1960s, cross-sectional efforts began to support increased diversification of the medical workforce. In 1963, Congress passed the Health Professions Educational Assistance Act (P.L. 88-129, amending the Public Health Service Act or PHSA) in response to a projected nationwide shortage of physicians. The act was the first comprehensive legislation to address the supply of health care providers and initially authorized grants for the construction of new teaching facilities and loans to support students in the study of medicine, dentistry, and osteopathic medicine. The emphasis of Title VII programs shifted through several reauthorizations in the 1970s and 1980s. Title VII programs were seen as a means to improve the maldistribution of physicians and other health professionals. Programs were authorized to increase the numbers of health professionals in underserved (mostly rural or inner-city) areas and to improve the racial and ethnic diversity of the health workforce by increasing the numbers of those who had been historically excluded from careers in medicine. In addition, programs were developed to counter the nationwide trend of medical specialization. The major objective of these programs was to increase support for training and curriculum development in primary care.[9] Title VII programs are administered by the Bureau of Health Professions at the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (HHS).

The adoption of pathway programs by the Association of American Medical Colleges (AAMC) as a strategic way to increase the number of URM physicians also emerged from the civil rights activism of the 1960s. Nickens et al. explain that "actions to promote diversity in medical schools reflected the heightened sensitivity to racial injustice spurred by the civil rights movement."[10] In 1964, only 2.2 percent of the total 32,000 medical students enrolled nationwide were Black, and the two historically Black colleges and universities (HBCUs) enrolled 76 percent of these students. On average all other medical schools enrolled a single Black student every two years.[8] At the 1968 AAMC annual meeting, medical students, faculty, and administrators asked for the creation of a task force and strategies to increase enrollment among URM students. The underrepresentation of these groups was found to be so great that the task force placed highest priority on increasing the number of URM medical students from 2.8 percent to 12 percent within five years.[9] The other recommendations centered around retention of students on the medical career pathway, providing financial assistance, and recruitment of students into the medical pathway.[9] At the same time, there was widespread implementation of new "academic-enrichment programs" for premedical and post-baccalaureate students.[8] These enrichment programs as well as a rise in Black college student enrollment and the use of affirmative action in medical school admission led to a rapid increase in medical student enrollment among URM students from 3 percent in 1968 to 10 percent by 1974.[11] Data on the enrollment of non-Black minoritized individuals was not collected until 1971.

Although these programs remained in place from 1974-1990, the general population rate of minoritized communities increased faster than medical school enrollment among those who had been historically excluded from medicine, so there was greater underrepresentation of these groups in medical schools in 1990 than in 1975. By 1990, the general minoritized population was 20 percent while URM medical students represented 9 percent of all medical students. In 1990, the AAMC launched the *3000 by 2000* initiative, which aimed to enroll 3000 URM medical students annually by the year 2000. As part of this initiative, the AAMC adopted the "pipeline" metaphor that had been previously used in the science and engineering fields.[10] The first major aspect of this initiative encouraged medical schools to partner with local magnet high schools to provide minoritized students early exposure to the health professions and to academically prepare students to undertake rigorous pre-medical or pre-health professional coursework in college. The second aspect of the initiative included forming more articulated agreements between undergraduate

institutions and medicals schools to encourage the enrollment and advancement of URM students into and through medical school. Last, the initiative encouraged science-education partnerships between academic health education centers (AHECs) and local primary school systems wherein AHEC faculty helped design scientific curricula that encouraged critical thinking and problem solving rather than simple memorization in the public school system. Although the *3000 by 2000* initiative did not achieve its enrollment goal, partially due to national resistance against affirmative action at the time, it paved the way for widespread pathway partnerships between medical schools, undergraduate institutions, and primary schools, many of which remain to this day.[10]

In 2009, the Liaison Committee on Medical Education (LCME), which accredits medical education school programs in the United States and Canada, revised its diversity standards to require that all U.S. allopathic medical schools engage in systemic efforts to attract and retain students from diverse backgrounds. The diversity standards were defined by the medical schools and the standards did not set numerical goals, but sought to ensure that all medical schools had a "mission-appropriate" diversity policy.[12] Evaluation of these medical school programs, some of which are pathway programs, has demonstrated modest enrollment increases in the proportions of URM medical students.[4] According to data collected for the 2019-2020 academic year, 149 (97 percent) of LCME-accredited medical schools have or support at least one pathway program to prepare participants (from the school's diversity categories) for potential admission to medical school. Table 1 summarizes the types of "pipeline programs" in U.S. MD-granting medical schools.

Table 1 Types of Pipelines Programs in U.S. MD-Granting Medical Schools, 2019-2020

Type of Pipeline Program[a]	No. (%) of Medical Schools[b]
Pre-college-level only	6 (4.0)
College-level only	13 (8.7)
Postbaccalaureate only	1 (0.7)
Pre-college and college-levels	59 (39.6)
Pre-college, college, and postbaccalaureate levels	54 (36.2)
College and postbaccalaureate levels	12 (8.1)
Pre-college and postbaccalaureate levels	4 (2.7)

Source: LCME, 2020

[a]Pre-college level includes programs at the middle school and/or high school levels
College level includes programs at the college/university level and/or BA/MD programs/guaranteed medical school admission programs
Postbaccalaureate programs include programs for college graduates to complete additional course requirements or other pre-medical requirements

[b]149 medical schools reported having one or more pipeline programs: middle school (69 schools), high school (122 schools), college/university (123 schools), BA/MD or guaranteed admission programs (49 schools), postbaccalaureate programs (71 schools)

Table 2 summarizes the number of new medical students matriculating into a U.S. MD- or DO-granting medical school who came from at least one of a school's supported pathway programs.

Table 2 New Medical Students Who Came from a Pathway Program in 2019-2020

Type of Program	# Matriculating to Respondent's Medical School	# Matriculating to Another U.S. MD/DO Granting Medical School
Middle school program only	7	0
High school program only	158	55
College program only	872	580
BA/MD/guaranteed-admission program only	921	47
Postbaccalaureate program only	907	637
More than one type of the school's pipeline program	210	39

Source: LCME, 2020

However, although absolute numbers of Black and Hispanic/Latinx matriculants have increased since 2009, representation of these groups in medicine as a proportion of the general population has not increased.[5] Additionally, Lett et al. found "no statistically significant trend towards increased representation of Black and Hispanic/Latinx male individuals and a modest trend towards increased representation for Hispanic/Latinx female applicants." In fact, they found "that Hispanic/Latinx individuals are underrepresented among medical school applicants and matriculants by nearly 70% relative to the age-adjusted U.S. population; Black male applicants and matriculants, nearly 60%; Black female applicants, nearly 30%; and Black female matriculants, nearly 40%." Additionally, Lett et al demonstrated that the representation of minoritized faculty relative to the general population has actually decreased in almost all specialties and across all faculty rankings since 2009.[13]

EVOLUTION FROM "PIPELINE" TO "PATHWAY" PROGRAM

It is important to consider the implications of using specific terminology about programs focused on increasing diversity in medicine. The term "pathway program" is gaining favor as it suggests a more open and flexible path to becoming a physician; the term "pipeline program," however, is still prevalent both in the literature and in everyday conversations. Some believe the metaphor of the "pipeline" is misleading and inaccurate. The pipeline metaphor suggests there is a single path to becoming a doctor with a single entry and exit point.[14] Many URM medical students follow a non-traditional path to medical school, such as participating in post-baccalaureate programs to strengthen their academic profile, so the idea of a rigid pipeline that requires early access and success in science and medicine may be particularly discouraging to minoritized students.[13] Giordani et al. demonstrated that non-traditional students with lower Medical College Admission Test (MCAT) scores and undergraduate GPAs who pursue post-baccalaureate programs are just as likely as their traditional peers to succeed once they enter medical school.[15] Another reason some criticize the term "pipeline" is its allusion to the "school-to-prison pipeline," a phenomenon known to disproportionately impact minoritized youth.[16] While the criminalization of minoritized children in schools is a worthwhile concern to address in pathway programs—minoritized students cannot be guided toward academic success when trapped in a "pipeline" of isolation, punishment, aggressive school policing, and inadequate academic preparation due to lack of resources—echoing the same terminology for a program promoting equity is inappropriate. Additionally, the word "pipeline" has negative connotations in Native American communities that are a prioritized group for recruitment. "Pipelines" within Indigenous communities are often literal, calling to mind current struggles with oil industries against environmental degradation, threats to communities' health and safety, and continued colonization. Alternatively, the term "pathway" implies learners' agency and offers more than a single path to medicine, which can include non-traditional students,

individuals who change careers later in life, and those who did not have early exposure to medicine.[13]

CURRENT FEDERAL PATHWAY PROGRAMS

The Title VII health professions and Title VIII nursing workforce development programs, which are authorized under the Public Health Service Act and administered by the HRSA, increase the supply, distribution, and diversity of the health care workforce, reaching over 400,000 participants.[17] These programs improve access to, and quality of care for, vulnerable populations, including children and families living on low incomes and in rural and underserved communities. In addition, as ever-changing public health threats such as the COVID-19 pandemic and substance use disorder epidemics, impact patients across the country, continued investment in Title VII programs is essential to addressing the health challenges of today and the future.

Title VII programs play an essential role in improving the diversity of the health care workforce and connecting students to health careers by supporting recruitment, education, training, and mentorship opportunities. Inclusive and diverse education and training experiences expose physicians and other health care professionals to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients. The Title VII programs include:

- *Centers of Excellence*: Provides grants for mentorship and training programs. In academic year 2018-19, this program supported over 1,300 trainees, of whom 99% were underrepresented minorities and 64% were from financially or educationally disadvantaged backgrounds.

- *Health Career Opportunity Program*: Invests in K-16 health outreach and education programs through partnerships between health professions, schools, and local community-based organizations. In academic year 2018-19, over 4,000 students from rural and disadvantaged backgrounds were exposed to the health professions pathway.

- *Primary Care Training and Enhancement (PCTE*): Supports training programs for physicians and physician assistants to encourage practice in primary care, promote leadership in health care transformation, and enhance teaching in community-based settings. In academic year 2018-19, PCTE grantees trained over 13,000 individuals at nearly 1,000 sites, with 61% in medically underserved communities and 30% in rural areas.

- *Medical Student Education:* Supports the primary care workforce by expanding training for medical students to become primary care clinicians, targeting institutions of higher education in states with the highest primary care workforce shortages. The grants develop partnerships between institutions, federally recognized tribes, and community-based organizations to train medical students to provide care that improves health outcomes for those living on tribal reservations or in rural and underserved communities.

- *Area Health Education Centers (AHECs)*: Responds to local health needs and serves as a crucial link between academic training programs and community-based outreach programs. In academic year 2018-19, AHECs supported 192,000 pathway program participants, provided over 34,000 clinical training rotations for health professions trainees, and placed over 92,000 trainees in rural and underserved training sites.

- *Mental and Behavioral Health*: Funds training programs to expand access to mental and behavioral health services for vulnerable and underserved populations. In academic year 2018-19, the Graduate Psychology Education program partnered with 184 sites to provide clinical training experiences for psychology students. Of these sites, 48% offered substance use disorder treatment services, and 38% offered telehealth services.

HRSA also administers the Minority Faculty Fellowships Program, with the goal of increasing the number of minoritized faculty at awardee institutions. The program awards 50 percent of faculty salary, with the institution matching funds. Fellows are prepared to assume tenured faculty positions at the institution and to provide services in underserved areas.[8]

Additionally, and as previously reported in Council on Medical Education Report 5-A-18, "Study of Declining Native American Medical Student Enrollment," the Indian Health Service (IHS) supports American Indian/Alaska Native (AI/AN) entry into the health professions and provides opportunities to explore career paths in AI/AN health care. The IHS Scholarship program has awarded more than 7,000 health professions scholarships since 1978. The IHS website provides links to allow potential students to arrange IHS externships (with salary) and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of $20,000 per year of commitment (maximum $40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to $50,000 for a two-year commitment.[18]

CURRENT UNDERGRADUATE PATHWAY PROGRAMS

The CUNY School of Medicine (formerly Sophie Davis Biomedical Education Program), located in Harlem, recruits and educates a diverse, talented pool of students to its MD and physician assistant programs, expanding access to medical education to URM individuals from underserved communities of limited financial resources. The BS/MD degree program admits students directly from high school into an undergraduate biomedical program with a seamless transition into the medical school curriculum based on a seven-year curriculum. The program has graduated over 2,000 alumni who have become physicians, many of whom practice in underserved communities.

The Summer Health Professions Education Program (SHPEP) was initially established following a study by the Robert Wood Johnson Foundation (RWJF) in 1984 to identify strategies to reverse trends dating back to 1977 of declining URM medical school applicants. The program was originally known as the Minority Medical Education Program (MMEP), which was intended to increase the acceptance rates among medical school applicants who were African Americans, Mexican Americans, mainland Puerto Ricans, and AI/AN, as these groups have historically been underrepresented in medicine due to structural racism. Over the years, MMEP's intensive academic preparation program expanded to 11 medical school campuses and the AAMC assumed the role of National Program Office in 1993. The program changed its name in 2003 to the Summer Medical Education Program (SMEP) to reflect the inclusion of students representing a range of economic, cultural, and geographic diversity. The program continued to evolve in 2006 when it expanded to include dentistry and was renamed the Summer Medical and Dental Education Program (SMDEP). SMDEP focused on students in the first two years of their college education because the experience of previous programs indicated that this is when students derive the most benefit. Most recently, the program expanded again in 2016 to include a range of health professions due to the growing importance of team-based care and interprofessional collaboration, leading to the most recent change in the program name, to SHPEP.[19] As of 2020, the program has served 27,164 participants at 12 universities across the U.S.

Doctors Back to School (DBTS) was launched by the AMA Minority Affairs Consortium (now called the Minority Affairs Section) in 2002. The DBTS program encourages Black, Indigenous, and Hispanic/Latinx students to enter the health care pathway through conversations with these children in a classroom setting. DBTS has developed a Doctors Back to School™ Kit to support physicians and medical students who act as role models by visiting elementary and high schools to talk with marginalized students about careers in medicine. The program demonstrates to marginalized students that a medical career is well within their reach. In 2016, the program declared the second Wednesday in May as National Doctors Back to School™ Day.

The American Academy of Ophthalmology and the Association of University Professors of Ophthalmology partnered to provide first- and second-year URM medical students one-on-one mentorship, valuable guidance in medical career planning, networking opportunities, and access to a variety of educational resources through their Minority Ophthalmology Mentoring (MOM) program. The MOM Class of 2020 provided opportunities for 50 students. Additionally, the National Medical Association developed the Rabb-Venable Excellence in Ophthalmology Research Program to help increase exposure to ophthalmology as a potential specialty choice among URM students and residents/fellows.

In addition to these national programs, there are numerous programs in the U.S. to boost diversity across the medical continuum. Mentoring in Medicine (MIM) prepares marginalized students in 3rd grade to become biomedical professionals by enabling them to interact with, and learn from, experienced health care professionals and scientists from health professional schools around the U.S. MIM offers an array of age-appropriate programs that involve reaching out to students on a regular basis, creating supportive social circles, providing academic enrichment, exposing students to hospital and research environments, coaching them on leadership and life skills, and providing prospective medical students with exposure to a supportive, but rigorous boot camp. Tour for Diversity (T4D) educates, inspires, and cultivates the future generation of URM physicians, dentists, and pharmacists by conducting national tours in February and September to provide comprehensive workshops to high school and college students that focus on motivating them toward a strong career path, building critical skills, optimizing the application process, and developing mentoring relationships. T4D also provides students with virtual opportunities via hosted webinars that are both interactive and recorded. Building the Next Generation of Academic Physicians (BNGAP) was established in 2008 to address the lack of URM individuals serving as faculty at academic health centers and works to promote diversity and inclusion in the academic medicine workforce.

There are also programs that focus on the development of the health care workforce to increase access to care for underserved people such as those in rural communities. Successfully Training and Educating Pre-medical Students (STEPS) aims to increase the number of primary care physicians in northeast Kentucky by providing opportunities such as physician shadowing, mock interviews, and MCAT practice exams for pre-medical students in the Appalachian region. Frontier Area Rural Mental Health Camp and Mentorship Program (FARM CAMP) strives to reduce the shortage of behavioral health professionals in rural Nebraska. FARM CAMP offers a week-long camp to teach high school students in rural and tribal communities about different career options in behavioral health and provides mentorship after the camp ends. Frontier and Rural Workforce Development New Mexico (FORWARD NM) Pathways to Health Careers was established to address the chronic shortages of primary care physicians and other health care professionals in New Mexico's southwestern counties of Hidalgo, Catron, Luna, and Grant; additionally, New Mexico has the oldest physician population in the country. This comprehensive workforce pathway program includes programming for middle and high school students, undergraduate and graduate students, primary care program students, and medical and dental residents.[20]

Additionally, in 2010, Columbia University College of Physicians and Surgeons and Bassett Medical Center joined forces to launch a new model of medical training to address the severe shortage of rural physicians and train a new generation of doctors capable of leading health systems that promote both quality of practice and cost-effective delivery of care. Students begin their training for 18 months in Manhattan and then head to Cooperstown, N.Y., for two and a half years to obtain clinical training. Students experience both an urban health care setting and a rural health care environment, while being exposed to features not typically part of the medical school curriculum, such as finance, risk management, patient safety, quality improvement, and medical informatics. In addition, every Columbia-Bassett student receives grant funding at a minimum of $30,000 per year for all four years.

To help highlight the needs of the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community, in 2020 the American Medical Association Foundation (AMAF) established its LGBTQ Fellowship Program to influence the future of LGBTQ health. The new initiative will create a cadre of LGBTQ health specialists through a national fellowship program to promote best practices and shared outcomes, while improving the quality of LGBTQ health care across the nation. The program was created to address the intersectional issues of discrimination, stigma, and limited access to and lower quality of care experienced by lesbian, gay, bisexual, and transgender individuals. A primary goal of the program is to create a pathway for LGBTQ health specialists who are able to serve the health care needs of the LGBTQ community while growing the pool of competent instructors able to “pay it forward” by passing on their knowledge to the next generation of LGBTQ physicians.

CURRENT GRADUATE MEDICAL EDUCATION PATHWAY PROGRAMS

There are also initiatives to increase diversity in competitive specialties such as orthopaedic surgery and radiology, as well as expand gender equity in the specialties of family medicine and obstetrics and gynecology. Nth Dimensions was founded in 2004 by orthopaedic surgeons working collaboratively with academic institutions, community surgeons, and industry to address the dearth of women and other URM groups in orthopaedic surgery. Nth Dimensions offers an eight-week clinical and research internship with a practicing researcher, which also includes a full-day orientation and culminates in the student presenting a research poster at the annual National Medical Association assembly. Following successful completion of the summer internship program, students receive scholarships to participate in a designated Step 1 board review course, which is conducted throughout their second year in medical school. Nth Dimension also offers clinical correlations lectures and hands-on workshops to increase awareness of the specialty being addressed through surgeon-led lectures and hands-on workshops with target groups of URM groups and women. The American College of Radiology established the Pipeline Initiative for the Enrichment of Radiology (PIER) internship program for first-year medical students at institutions across the U.S. in hopes of giving women and other URM groups an opportunity to explore the radiology specialty and engage in research. The internship begins in June and culminates with presentation of the students’ research to the radiology section of the National Medical Association. Additionally, the AMA Reimagining Residency initiative is currently sponsoring two innovative pathway programs. California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) is a collaboration between Oregon Health & Science University and University of California, Davis, 10 health care systems, 10 institutional sponsors, and a network of federally qualified health centers that aims to jointly address workforce shortages in rural, tribal, urban, and other disadvantaged communities between Sacramento and Portland. The University of North Carolina has developed Fully Integrated Readiness for Service Training (FIRST): Enhancing the Continuum from Medical School to Residency to Practice, which expands the geographic and specialty reach of the University of North Carolina School of Medicine’s

established residency readiness program. Its additional aims include developing and implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum.

INSTITUTIONAL AND STRUCTURAL FACTORS THAT INTERFERE WITH PATHWAY PROGRAM SUCCESS

Although many students who indicate an early interest in medicine do not progress from one phase to the next, the attrition rate of URM medical students is even higher than those of their non-minoritized counterparts.[1,21] This disproportionate attrition rate is multifactorial and occurs in all phases of the pathway. Some factors that disproportionally affect URM students include attending lower performing high schools and colleges, financial barriers to higher education, lower levels of academic attainment among parents of minoritized students (which has been found to link to a child's outcomes such as academic achievement), and experiences of racism and implicit bias that deter students from continuing with their trajectory.[4,10] A 2019 study published in *JAMA* found that while the U.S. population of male and female 24- to 30-year-olds, who are Black, Hispanic/Latinx, and Native Hawaiian or Pacific Islander (NHOPI) increased between 2002 and 2017, there were no significant increases in medical school applicants and attendees from these groups over the same period. The study also found that from 2002 to 2012, the proportion of Black, Hispanic/Latinx, NHOPI, and AI/AN medical school matriculants remained relatively unchanged and Black, Hispanic/Latinx, and AI/AN students remain underrepresented among medical school matriculants compared with the U.S. population.[5] Another study the same year found that as medical school enrollment doubled over the past two decades, the percentage of entering underrepresented students actually fell by 16%.[22] There are several possible factors that may explain why these groups are still underrepresented in medicine.

While affirmative action efforts helped initially increase enrollment among URM medical students, these initiatives have been met with resistance. In 1974, a reverse discrimination lawsuit brought by Allan Bakke against the University of California (UC) transformed how colleges think about race and equality in admissions. Bakke was a white man who had twice been denied admission to the medical school at UC Davis during the time when positions in the entering class were "reserved" for qualified minoritized students. The case was ultimately heard by the U.S. Supreme Court. Justice Lewis Powell, in the deciding opinion in the case, wrote "the State has a substantial interest that legitimately may be served by a properly devised admissions program involving the competitive consideration of race and ethnic origin" and concluded that "you could use race as a factor in admissions, but that you could not use quotas" (Powell L. 1978. Bakke*,* 438 US at 312–13 n.48). The Court's decision in *Regents of the University of California v. Bakke* changed the definition of the Equal Protection Clause and inadvertently changed how colleges approached recruiting and enrolling URM in medicine. According to law professor Kevin Brown at Indiana University, the Equal Protection Clause is a short but critical line in the Fourteenth Amendment that states that Americans in similar circumstances should be treated equally under the law. This clause historically aimed to help "discrete and insular minoritized groups."[23] The decision upended that view. Bakke was admitted to medical school at UC Davis and the school transitioned to a panel of markers that they term "distance traveled," which is not race-based but serves to support marginalized people based on non-race indicators of socioeconomic disadvantage. However, the Court's decision affirmed the use of race as one among many factors that could be considered as part of the medical school admissions process.[10] The Court's decision provided the window to weaken the practice of race-based affirmative action and as a result enrollment among minoritized groups stagnated.

There were additional anti-affirmative action initiatives to follow that negatively impacted efforts to increase diversity in medicine. Most notable was *Hopwood v. University of Texas* in 1996, in which the United States Court of Appeals for the Fifth Circuit held that "any consideration of race or ethnicity by the law school for the purpose of achieving a diverse student body is not a compelling interest under the Fourteenth Amendment."[24] This decision prohibited public universities under its jurisdiction (in Texas, Mississippi, and Louisiana) from taking race into account in their admissions policies. The same year, Proposition 209 was passed in California with nearly 55 percent of the vote, banning consideration of race and gender in admissions in the state's public universities. In 2008, the University of California (UC) "clarified" their policy in recognition that Native Americans enrolled in a federally recognized tribe enjoy a political status that enables them to be offered affirmative action, even when the consideration of race or ethnicity is banned. This policy shift led to a statistically significant surge in the Native American applicant share, acceptance rate, admit share, and enrollment share. Enrollment share increased by 56% from 2008 to 2010 at the UC.[25] In November 2020, nearly 25 years later, voters in California had the opportunity to repeal Proposition 209 through the work of Assemblywoman Shirley Weber (D-San Diego), chairwoman of the Legislative Black Caucus and principal author of the proposed constitutional amendment.[26] This effort was unsuccessful, and the amendment was not approved by voters. Presently, Arizona, Georgia, Michigan, Nebraska, New Hampshire, Oklahoma, and Idaho have banned affirmative action. A study of 19 public universities in six of these states (Arizona, Georgia, Michigan, Nebraska, New Hampshire, and Oklahoma) found that the elimination of affirmative action has led to persistent declines in the share of URM medical students among students admitted to and enrolling in flagship public universities in these states.[27]

In June 2003, the US Supreme Court ruled on two separate but parallel admissions cases, *Grutter v. Bollinger* and *Gratz v. Bollinger*, involving the University of Michigan and the constitutionality of using race-conscious decisions as part of its admissions process. Although neither case directly involved the medical school or other health profession admissions, the Court's ruling was widely recognized as one that would have profound bearing on the future of affirmative action in public higher education nationwide. With these rulings, the Supreme Court recognized the value of diversity in higher education and preserved the ability to consider race as a factor in admissions decisions.[10]

Aside from the impact of court rulings on affirmative action, support for Title VII programs has been inconsistent over the last decade. In 2005, the Office of Management and Budget (OMB) published its review of the health professions training programs under Title VII. After years of effective ratings for Title VII programs, the OMB concluded that these programs were ineffective. As a result, the HRSA administrator, Elizabeth Duke, informed COE and HCOP grantees that the administration would no longer support their programs, and in 2006, the federal government cut its funding abruptly and drastically reduced the number of Centers of Excellence and Health Careers Opportunity Programs. In February 2006, the Government Accountability Office (GAO) issued a report entitled *Health Professions Education Programs: Action Still Needed To Measure Impact,* which reviewed HRSA's evaluation of the Title VII and VIII (nursing) programs against its overall performance goals and found that these goals did not apply to all of the health professions programs and that HRSA's tracking data was problematic.[28] HRSA was criticized for failing to publish national supply, demand, and distribution projections for the physician and dentist workforces.

In July 2020, the House Appropriations Committee released their Committee Report accompanying the Labor-HHS-Education FY 2021 allocations, which would provide Title VII Health Professions and Title VIII Nursing Workforce Development Programs with a total of $782.5 million, a $48 million increase (6.5%) from FY 2020 enacted levels.[29] In December 2020, the Consolidated

Appropriations Act of 2021 passed which includes $50,000,000 for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care physician shortage in 2025 and are limited to public institutions in states in the top quintile of states with a projected primary care physician shortage in 2025.[30]

Historically, disparities in medical school admissions have encompassed more than racial and ethnic gaps. One root cause for this disparity is a lack of resources to support the development of education necessary to be an adequate applicant for medical school admission. While overall educational attainment is increasing, college completion rates and attainment patterns differ considerably across demographic groups. Household income and education levels are tightly linked. Consequently, lower levels of education are correlated with lower household income as well.[31] This has direct implications for the economic diversity of applicants to medical school. According to a 2018 study conducted by AAMC, roughly three quarters of medical school matriculants come from the top two household-income quintiles, and this distribution has not changed in three decades. Black and Hispanic/Latinx medical students are three times as likely as their white counterparts to come from families with combined parental incomes of less than $50,000. Black and Hispanic/Latinx students are also much more likely than white students to have attended high poverty primary and secondary schools which strongly affects educational achievement and often leaves these individuals less competitive on traditional academic measures such as MCAT scores and grade-point averages.

The lower admission rate for URM groups is another challenge to diversification of the medical workforce due to bias. Community college attendance is often viewed negatively by medical schools in the admissions process, despite being a critical educational pathway for many URM students.[31] To counter this bias, there is a growing trend of holistic review as an admissions strategy to assess an applicant's unique experiences alongside traditional measures of academic achievement such as grades and test scores. It is designed to help admission committees consider a broad range of factors reflecting the applicant's academic readiness, contribution to the incoming class, and potential for success, both in school and later as a professional. Holistic review, when used in combination with a variety of other mission-based practices, constitutes a "holistic admission" process. A key element is that this review concomitantly reduces historical singular focus on metrics that are flawed from the perspective of equity for URM medical students, specifically standardized testing and GPA or the "caliber" of college attended. A holistic admission process is necessary at the collegiate level to increase the pool for subsequent undergraduate medical education, GME, and faculty recruitments. In 2003, the U.S. Supreme Court officially described the strategy as a "highly individualized, holistic review of each applicant's file, giving serious consideration to all the ways an applicant might contribute to a diverse educational environment" (*Grutter v. Bollinger*, 539 US 306, 2003). The AAMC has promoted holistic review in the admissions process to broadly assess how a candidate might contribute value as a medical student and physician. Although practices vary widely, a national survey of health professional schools showed that institutions incorporating "many elements of holistic review" reported increases in class diversity as compared with institutions incorporating few or no elements.[32]

Diversity in the ranks of faculty and administration of medical schools is central to creating a welcoming environment for all students.[31] However, a study to evaluate trends in racial, ethnic, and gender representation at U.S. medical schools across 16 specialties from 1990–2016 found that the gap between the URM population in the academic physician workforce widened over time for nearly all specialties and faculty rankings.[33] This is problematic, as URM faculty often serve as important role models and mentors for URM medical students and trainees who may struggle with systemic racism in their schools and training environments.[34] URM faculty can also promote

academic excellence and enhance training across all domains to improve outcomes for all students related to cultural humility, humanism, empathy, and professionalism. "Most institutions recognize the value of multi-cultural outreach and engagement, but often fail in reconciling the associated implications for organizational decision-making. In other words, institutional leaders recognize the benefits of recruiting URM groups into medicine and gaining ideas from diverse sources but lack the understanding or will to ensure that they are integrated into an environment of respect, inclusion and meaningful engagement."[34]

Lastly, negative social integration into the campus environment impacts retention among minoritized and marginalized groups. Tinto's theory of student departure claims that a student's individual characteristics (including personal attributes, family background, and high school experiences) directly influence the student's commitments to an institution, the goal of graduation, and, ultimately, the departure decision.[35] Braxton et al. revised the model in 2004 by placing social integration as the pivotal factor in retention and claiming that student characteristics (e.g., gender, race/ethnicity, socioeconomic status, academic ability, high school preparation, and self-efficacy) shape initial commitments to attaining a degree and to the institution.[36] Significant factors for minoritized and marginalized student retention include racial climate, presence of an ethnic community, community orientation, campus involvement, acclimation to the academic culture, social connectedness, and the role of religion.[37] These factors may be interconnected as having the presence of a similar ethnic community may increase a student's feelings of support in the event of a racially insensitive incident. Some recent examples of these type of incidents include white students posting photographs of themselves in blackface and disseminating the photos via social media, along with graffiti with swastikas and other "hateful language" in dormitories and on campus buildings; however, incidents do not have to be blatant to be harmful.[38] Microaggressions which are brief yet common verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color can also negatively impact one's experience in the classroom, training environment and workplace. URM groups have reported commonly experiencing microaggressions in school and in the workplace. These experiences of microaggressions have been associated with harmful psychological outcomes including anxiety and depression. Moreover, because microaggressions seem benign, they are rarely reported in the workplace.[39] The absence of a supportive affinity community may lead a student to experience an estrangement process, which begins with feelings of alienation that evolve into disillusionment and emotional rejection, and end with the student physically rejecting the campus environment and withdrawing from the institution.[40]

ADDITIONAL CONSIDERATIONS FOR PATHWAY PROGRAMS

As the focus of this report is on existing promising practices to promote a diverse medical workforce, the Council would like to address the importance of gender equity across medical specialties. Table 3 highlights the gender imbalances among the medical specialties according to the 2018 National GME Census, which is compiled by the AMA and the AAMC. It is worth noting the lack of data on physicians who identify as non-binary when evaluating the balances in the specialties.

Table 3 Top Medical Specialties by Gender, 2018-2019

Female-dominated specialties		Male-dominated specialties	
Obstetrics and gynecology	83.4%	Orthopaedic surgery	84.6%
Allergy and immunology	73.5%.	Neurological surgery	82.5%
Pediatrics	72.1%	Interventional radiology (integrated)	80.8%
Medical genetics and genomics	66.7%	Thoracic surgery	78.2%
Hospice and palliative medicine	66.3%	Pain medicine	75.3%
Dermatology	60.8%	Radiology	73.2%

Source: 2018 National GME Census

While efforts are underway to increase diverse representation in orthopaedic surgery and radiology, recent attention has also been given to the dramatic decline of men in obstetrics/gynecology. In an effort to identify how to recruit more male students into the field of obstetrics/gynecology, a study was conducted to identify when students make their decisions on career choice and found that >70% of obstetrics/gynecology residents decided to pursue the specialty during or after their third-year clerkship.[41] Another study found that 78% of male students believed their gender adversely affected their obstetrics/gynecology clerkship experience.[42] The authors recommended the following efforts to increase representation of men in obstetrics/gynecology: improving the quality of the obstetrics/gynecology clerkship experience, engaging students early in their medical school careers, and frankly addressing gender and lifestyle issues that dissuade students from choosing obstetrics/gynecology.

RELEVANT AMA POLICY

Our AMA has a number of existing policies and directives that are relevant to the topic of pathway programs; these are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

There is limited evidence on the effectiveness of pathway programs and more rigorous evaluation is needed. That said, the following promising practices to increase diversity across the various educational settings are supported in the literature: targeted recruitment; revised admissions policies; summer enrichment programs; and comprehensive programs that integrate multiple interventions such as financial, academic, and social support.[43] Snyder et al. found that "high quality studies suggest that pipeline program interventions can exert a meaningful, positive effect on student outcomes."[44] The limited evidence available provides reason to be optimistic that these programs are beneficial. For example, a study of three HCOP projects in Kentucky, Tennessee, and Virginia during the years 1990-1999 found that students who participated in HCOP programs were likely to enroll in college (93 percent), major in a health profession program (77 percent), and graduate (58 percent). A total of 87 percent of those who graduated from college were enrolled in a health professions program.[45] Efforts to increase diversity in medicine are needed across multiple levels. Where legally possible, institutions should utilize affirmative action policies to bolster efforts to increase diversity in medicine. University leaders committed to diversity should select deans of their medical programs with a record of active support in this area. Medical programs, through their leaders, at the school and department levels, should support continuing pathway efforts by making statements of support, by cultivating and funding programs that support a culture of diversity on campus, and by recruiting faculty and staff who share this goal. Policymakers at the state level must work to alleviate pre-K-12 educational disparities and improve the college readiness of URM students. Additionally, the efforts to increase gender equity across medical specialties should be encouraged as diverse learners add value to medical education and research

environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.

The Council on Medical Education therefore recommends the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, sexual orientation, and gender identity due to structural racism and other systems of oppression. (New HOD Policy)

2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity. (New HOD Policy)

3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. (New HOD Policy)

4. That our AMA work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. (New HOD Policy)

5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce by addition and deletion to read as follows: (4) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support historically underrepresented groups in medicine, by developing policies that articulate~~ing~~ the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this ~~and strategies to accomplish that~~ goal. (5) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of minoritized and marginalized patient populations. (Modify Current HOD Policy)

6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights (3) by addition to read as follows: Our AMA will support and encourage the U.S. Department of Education to develop policies and initiatives to 1) increase the high school graduation rate among historically underrepresented students 2) increase the number of historically underrepresented students participating in high school Advanced Placement courses and 3) decrease the educational opportunity gap. (Modify Current HOD Policy)

7. That our AMA amend Policy D-200.985 (13), "Strategies for Enhancing Diversity in the Physician Workforce," by deletion to read as follows: ~~(a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine~~

~~and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and.~~ (Modify Current HOD Policy)

8. That our AMA reaffirm Policy D-200.982, "Diversity in the Physician Workforce and Access to Care."

Fiscal note: $5,000.

APPENDIX: RELEVANT AMA POLICY

D-200.982, Diversity in the Physician Workforce and Access to Care

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

D-200.985, Strategies for Enhancing Diversity in the Physician Workforce

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

D-305.972, Title VII Funding

Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of $300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.

H-180.944, Plan for Continued Progress Toward Health Equity

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

H-200.951, Strategies for Enhancing Diversity in the Physician Workforce

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

H-350.960, Underrepresented Student Access to US Medical Schools

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

H-350.970, Diversity in Medical Education

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Code of Ethics 8.5, Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(JUN-21)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

Referred to: Reference Committee C

Whereas, There is a physician shortage facing our nation; and[i]

Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or older and in retirement age this year; and[i]

Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now more than ever the need for a sufficient and robust physician workforce; and[i]

Whereas, An unprecedented number of physicians now plan to retire in the next year and many of whom are under 45 years old and therefore would be retiring earlier than expected by workforce shortage predictors due to COVID-19; and[ii]

Whereas, 8% of physicians surveyed across the United States have closed their practices during the pandemic, amounting to approximately 16,000 closed practices further exacerbating the shortage of healthcare providers; and[iii]

Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across specialties who have reported loss of staff, lack of reimbursement, and closure of independent physician practices during the COVID-19 pandemic; and[iii,iv]

Whereas, Young physicians are expected to be part of the workforce for many years to come, yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were under 60 years old with primary care physicians (PCPs) accounting for a disproportionate number of these HCW deaths; and[v,vi]

Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already predicted to be between 2,500 and 17,000 by 2030; and[vii]

Whereas, During the pandemic, the shortage has been amplified in that New York City has had the highest COVID-19 death rate in the country with NYS accounting for the greatest number of HCW deaths in the USA; and[v,viii]

Whereas, 73% of medical students graduated with debt in 2020; and[ix]

Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting for inflation, affecting newer generations of students and physicians substantially more than past ones; and[x]

Whereas, The average medical student debt is $207,003--an approximately 28% increase in the past 10 years--however, the average physician ultimately pays $365,000-$440,000 for an educational loan with interest; and[ix,x,xi]

Whereas, In the United States, 50% of low-income medical school graduates have educational debt that exceeds $100,000; and[x]

Whereas, The financial barrier to entry into medical school is significant in that over half of medical students belong to the top quintile of US household income, with 20-30% of students belonging to the top 5% of income; however, only less than 5% of students come from the lowest quintile of US household income; and[x]

Whereas, A recent study found that higher debt levels among medical students is more likely to motivate them to choose higher paying specialties than primary care specialties; and[xii]

Whereas, Higher burdens of educational debt has been demonstrated to cause residents to place greater emphasis on financial considerations when choosing a specialty; and[xiii]

Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that has been studied previously in natural disasters and has been shown to persist for years; and[xiv,xv]

Whereas, It is well-established that health inequities existed before the pandemic in that individuals with low socioeconomic status are more likely to also be from minority populations, and are more likely to have worse health outcomes; and[xvi]

Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and[xvii]

Whereas, Over 27 million Americans have lost their employer-sponsored health insurance during the pandemic; thus, we will need more physicians now than ever before to address these disparities and rising needs in health care; and[xviii]

Whereas, 72% of physicians surveyed across specialties reported loss of income during the pandemic, with over half of these respondents reporting losses of 26% or more; and[iii]

Whereas, Policies modeled to include provisions for debt relief or increase in incomes were found by one study to be more likely to incentivize students to choose primary care physician specialties; and[xix]

Whereas, Current AMA policies support methods to alleviate debt burden but do not address debt cancellation specifically; and

Whereas, $50 billion of the initial CARES Act Provider Relief Fund were allocated to support the current healthcare system by giving hospitals and providers funding “to support health care-related expenses or lost revenue attributable to COVID-19...”; however, funding formulas based on market shares of Medicare costs and total patient revenue are most likely to bankrupt independent physicians, specifically primary care providers; and[xx,xxi]

Whereas, One study found that primary care internists whose medical education were funded through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

significantly less net present value than primary care internists who received military or private funding; and[xxii]

Whereas, Medical education debt has been shown to be a significant barrier for underrepresented minorities and low/middle income strata students to choose medicine for a career; and[xxii]

Whereas, A key strategy to address health needs of underserved communities involves recruiting students from these communities as they may be more likely to return to address local health needs; and[xxiii]

Whereas, One medical school has created a debt-free program for matriculated students and saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in applicants from groups underrepresented in medicine to help address socioeconomic and racial/ethnic disparities in the medical workforce and in healthcare; and[xxiv]

Whereas, There is currently a student debt forgiveness resolution in the United States Senate to cancel $50,000 of student debt which will also apply to all medical students, training physicians, and early career physicians; and[xxv]

Whereas, Data suggests women and people of color will benefit most from such debt cancellation because they are most in need; therefore be it[xxv]

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action)

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

Received: 04/23/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHOR'S STATEMENT OF PRIORITY

Students, training and attending docs are facing increasing amounts of administrative, regulatory and financial pressures that take a toll and cause increased rates of physician stress, demoralization, burnout and depression.
Data and experience show that physician stress and burnout result in reduced quality of care and reduced quality of patient-doc relationships and reduced patient satisfaction.
This loan forgiveness if achieved would reduce burdens on students and physicians and would contribute to reduced burnout and depression and mitigate reductions in quality of care that result from high levels of burnout.
Students and physicians need help now - this can't wait until the November AMA meetings.
Physician needs will be forgotten by the end of summer when we are projected to be near herd immunity.

RELEVANT AMA POLICY

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes,

and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i)

Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(JUN-21)

Introduced by: New York

Subject: Non-Physician Post-Graduate Medical Training

Referred to: Reference Committee C

Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use the title "physician"; and

Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health care advertising materials to clarify designate the level of education, skills, and training of all health care professionals promising their services"; and

Whereas, The Centers for Medicare and Medicaid Services defines a resident as "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board"; and

Whereas, There has been an increase in the number of physician assistant (PA) and nurse practitioner (NP) postgraduate programs, many of which are inappropriately referred to as "residencies" or "fellowships"; and

Whereas, On September 3rd, 2020, every major academic emergency medicine association issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship' in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within graduate medical education (GME) training programs"; and

Whereas, Several of these training programs pay their first-year trainees more than the first-year residents in physician residencies; therefore be it

RESOLVED, That our American Medical Association recognize that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians; thus these terms should be reserved to describe physician roles (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to define appropriate labels for postgraduate clinical and diagnostic training programs for non-physicians that recognizes the rigor of these programs but prevents role confusion associated with the terms "resident," "residency," "fellow," or "fellowship" (Directive to Take Action); and be it further

RESOLVED, That our AMA object to the American Board of Medical Specialists, the American Osteopathic Association Bureau of Osteopathic Specialists, and their member boards having designated seats for Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Anesthesia Assistants, or any other healthcare professional that are independent from the public member seats (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of postgraduate clinical training for non-physicians does not divert funding from physician graduate medical education. (Directive to Take Action)

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

Received: 04/26/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to recognize the unique skill set held by physicians and the important educational opportunities afforded to them. Words matter and it is important to provide clarity and transparency when describing the roles of physicians and allied healthcare professionals, especially for patients. It is important to act now given the increasing proliferation of post-graduate specialty training programs for physician assistants and nurse practitioners in the context of the simultaneous push to expand these non-physician practitioners' scope of practice using the ongoing COVID19 pandemic as an excuse.

RELEVANT AMA POLICY

Clarification of the Title "Doctor" in the Hospital Environment D-405.991
1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
Citation: (Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: Res. 218, A-12)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on

Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(JUN-21)

Introduced by: American Orthopaedic Foot & Ankle Society
American Academy of Orthopaedic Surgeons

Subject: Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE

Referred to: Reference Committee C

Whereas, According to the National Board of Medical Examiners (NBME), “All medical boards in the United States accept a passing score on the United States Medical Licensure Examination (USMLE) as evidence that an applicant demonstrates the core competencies to practice medicine. As a result, healthcare consumers throughout the nation enjoy a high degree of confidence that their doctors have met a common standard;” and

Whereas, Medical associations have long supported a uniform standard for licensing, including a public position saying that changes in licensure by non-MD/DO practitioners must be based on education, training, and experience, to ensure patient safety. This is the same position held by the American Podiatric Medical Association (APMA) and the American College of Foot and Ankle Surgeons (ACFAS); and

Whereas, Patients, as well as referring physicians should be able to have the same high degree of confidence that Doctors of Podiatric Medicine (DPMs) have also met this common standard as they provide medical and surgical care to patients within their scope of practice; and

Whereas, To accomplish this goal, and be considered physicians, DPMs should be required to receive sufficient education and training to take and pass all three parts of the USMLE; and

Whereas, AAOS, AOFAS, APMA, and ACFAS have collaborated and agreed upon the pathway for qualified DPM graduates to take all three parts of the USMLE; and

Whereas, The decision as to whether DPM students and graduates would be permitted to take the USMLE rests with the NBME and would be based in part on whether Council on Podiatric Medical Education (CPME) accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet NBME requirements; and

Whereas, Our AMA has the resources to objectively study these standards and if earned, its support would be beneficial to this process; therefore be it

RESOLVED, That our American Medical Association study, with report back at the 2021 Interim House of Delegates Meeting, whether Council on Podiatric Medical Education (CPME) accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet requirements which would allow Doctors of Podiatric Medicine (DPMs) to take all parts of the USMLE. (Directive to Take Action)

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

Received: 05/05/21

AUTHORS STATEMENT OF PRIORITY

The preservation of physician-led, team-based care impacts all physicians and patients, and fits squarely within the AMA's mission and strategic plan. Restricting the title "physician" to individuals with M.D. and D.O degrees is also important to the AMA's membership. Non-physicians have successfully prioritized increasing their scope of practice (SOP) and being given the title of physician through legislative and regulatory means, as opposed to meeting M.D./ D.O. standards of education and training. The pandemic has accelerated this activity with states creating 'temporary' waivers involving SOP, licensure and supervision. Once adopted, these changes are rarely reversed, with permanent seriously deleterious impact.

The AOFAS and AAOS have agreed with two national podiatric organizations on a process by which only podiatrists who meet M.D./D.O. standards for undergraduate and residency accreditation, board certification, and examination requirements would be considered physicians within their scope of practice. However, only the AMA, an organization representing all physicians, has the expertise and resources to evaluate and initiate this new process. Near-term action supporting this important policy of non-physicians being considered physicians by meeting physician standards, instead of lobbying legislators and regulators, will have a positive impact and improve patient care.

This resolution, originally intended to be introduced last year, only asks for a study. The more extensive discussion about what to do with the study results would be a future topic.

RELEVANT AMA POLICY

Definition of a Physician H-405.969
1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.
Citation: (CME Rep. 4-A-94 Reaffirmed by Sub. Res. 712, I-94 Reaffirmed and Modified: CME Rep. 2, A-04 Res. 846, I-08 Reaffirmed in lieu or Res. 235, A-09 Reaffirmed: Res. 821, I-09 Appended: BOT Rep. 9, I-09 Reaffirmed: BOT Rep. 9, I-11 Reaffirmation A-13 Reaffirmation A-15 Reaffirmed in lieu of: Res. 225, A-17 Reaffirmed: Res. 228, A-19)

Physician and Nonphysician Licensure and Scope of Practice D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to

patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
Citation: (CME Rep. 1, I-00 Reaffirmed: CME Rep. 2, A-10 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res. 251, A-18 Appended: Res. 222, I-19)

Non-Physician "Fellowship" Programs D-275.979
Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.
Citation: (CME Rep. 4, I-04 Reaffirmed: CME Rep. 2, A-14)

Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.
Citation: (Res. 317, I-94 Modified by Res. 501, A-97 Appended: Res. 321, I-98 Reaffirmation A-99 Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00 Reaffirmed: CME Rep. 1, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 208, I-10 Reaffirmed: Res. 224, A-11 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Res. 107, A-14 Appended: Res. 324, A-14)

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Citation: (Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: Res. 218, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Decreasing Financial Burdens on Residents and Fellows

Referred to: Reference Committee C

Whereas, Upon completion of medical school, trainees are often faced with significant financial burdens. According to the annual AAMC Graduation Questionnaire, 52.6% of medical students who graduated in 2019 had a combined premedical and medical school debt of $150,000 or more, with 26.2% reporting $200,000-299,000.[1]; and

Whereas, Between these financial restraints and 80-hour work weeks, trainees often struggle with having the time and budget for necessities, such as childcare, meals, and transportation to and from the hospital. When residency and fellowship programs provide benefits to assist with these needs, it can significantly improve trainee wellbeing; and

Whereas, For trainees looking at residency and fellowship programs, information on benefits offered by individual programs are essential to informed residency ranking. The recent 2019 expansion of the FREIDA database now includes the information requested in the RFS I-19 Report F recommendation.[2] Programs may report their employment policies and benefits, such as on-site child care, on-call meal allowance, free parking, and housing stipend. This data is collected through an AAMC survey of residency and fellowship programs, which has approximately a 95% response rate; and

Whereas, Of the total 11,949 active residency and fellowship programs, 11,296 responded to the survey. Of these, 7,566 (67%) indicated that they provide a meal allowance, 6,932 (61%) provided free parking, 798 (7%) subsidized child-care, and 3,330 (29%) on-site childcare. The number of programs offering each benefit varies widely between specialties, as can be seen in the below graph. Summary reports with this data are published by the AAMC every year.[3]; and

Whereas, While strides have been made in providing more resources to trainees and increasing transparency, there is clearly still much room for improvement in decreasing the financial burden on residents and fellows; and

Whereas, Though the ACGME has extensive institutional requirements regarding work hours, educational standards, and the provision of mental health resources, there are no standardized guidelines for GME programs on policies like childcare or transportation assistance. It is up to individual programs to decide what services to provide, leading to significant variance between specialties, institutions, and programs; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC), and other relevant stakeholders to advocate that medical trainees not be required to pay for essential amenities and/or high cost or safety-related, specialty-specific equipment required to perform clinical duties (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders including the AAMC to define "access to food" for medical trainees to include 24-hour access to fresh food and healthy meal options within all training hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare (Directive to Take Action); and be it further

RESOLVED, That the Residents and Fellows' Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs (Directive to Take Action); and be it further

RESOLVED, That the AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition and deletion to read as follows:

5. Our AMA partner with ACGME and other relevant stakeholders to encourage~~s~~ training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services. ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.~~ (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The AMA has an extensive catalogue of policy on GME trainee protections. However, there have been some gaps in trainee protections that have become more salient as the average trainee is getting older and in areas where enforcement of ACGME requirements has been lacking. This collection of asks will help strengthen the protections for vulnerable populations, ask for child care coverage which is in line with current AMA actions, and ensure that as the costs of medical education increase, it does not do so at the expense of the trainee.

REFERENCES
1. https://www.aamc.org/system/files/2019-08/2019-gq-all-schools-summary-report.pdf
2. https://freida.ama-assn.org/Freida/#/
3. https://www.aamc.org/system/files/reports/1/2018stipendsurveyreportfinal.pdf
https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600

RELEVANT AMA POLICY

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

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable

on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
Citation: CME Rep. 8, A-11Appended: Res. 303, A-14Reaffirmed: Res. 915, I-15Appended: CME Rep. 04, A-16Modified: CME Rep. 06, I-18Appended: Res. 324, A-19

Preserving Childcare at AMA Meetings G-600.115
Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings.
Citation: Res. 602, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Non-Physician Post-Graduate Medical Training

Referred to: Reference Committee C

Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use the title "physician."[i]; and

Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health care advertising materials to clarify designate the level of education, skills and training of all health care professionals promising their services" [ii]; and

Whereas, The Center for Medicare and Medicaid Services defines resident as "an intern, resident, or fellow who is formally accepted, enrolled, and participating in an approved medical residency program including programs in osteopathy, dentistry, and podiatry as required to become certified by the appropriate specialty board"[iii]; and

Whereas, There has been an increase in the number of physician assistant (PA) and nurse practitioner (NP) postgraduate programs, many of which are inappropriately referred to as "residencies" or "fellowships"[iv][v][vi]; and

Whereas, On September 3, 2020 every major academic emergency medicine association issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship' in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs"[vii]; and

Whereas, Several of these training programs pay their first-year trainees more than the first-year residents in physician residenciesviii; therefore be it

RESOLVED, That our American Medical Association believe that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-275.925 “Protection of the Titles "Doctor," "Resident" and "Residency",” by addition and deletion to read as follows:

Our AMA:
(1) recognize that the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “physician,” and “attending,” when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, as defined by the Centers for Medicare and Medicaid Services, and thus these terms must be reserved only to describe physician roles; (2) advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; (3) supports and develop model state legislation that would penalize misrepresentation of one’s role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “physician,” or “attending” in a healthcare setting except by physicians. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA study and report back, by the 2022 Annual Meeting, on curriculum, accreditation requirements, accrediting bodies, and supervising boards for graduate and postgraduate clinical training programs for non-physicians and the impact of non-physician graduate clinical education on physician graduate medical education (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME (Directive to Take Action); and be it further

RESOLVED, That our AMA partner with the Accreditation Council for Graduate Medical Education (ACGME) to create standards requiring Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships (Directive to Take Action); and be it further

RESOLVED, That policy H-310.912 “Resident and Fellow Bill of Rights,” be amended by addition and deletion to read as follows:

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows ~~should expect supervision by physicians and non-physicians~~ must be ultimately supervised by physicians who are adequately qualified and ~~which~~ allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~ In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest. (Directive to Take Action)

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

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

We present this Scope of Practice concern from the RFS for consideration by the HOD in lieu of others as this policy will have the greatest impact. The resolved clauses encourage a higher standard for our allied health colleagues in specialty fields, equal pay for trainees for equal work compared to the PA and NP colleagues we work side-by-side with, and a biennial study to track non-physician provider training standards and oversight. This is a worthwhile discussion that affects all areas of medicine. Given the recent ACEP report on the EM workforce and the influence of non-physicians on the workforce without specialty training, this issue is timely not only to those currently in training, but to the future of the profession. We cannot wait to be reactive when our patients and our profession are at stake.

[i] https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf
[ii] https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf
[iii] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf
[iv] https://www.aaem.org/resources/statements/position/em-training-programs-for--pas-and-nps
[v] https://appap.org/wp-content/uploads/2020/03/APPAP-Postgraduate-Program-Membership-Roster-by-Specialty-March-2020.pdf
[vi] 12. Association of Postgraduate Physician Assistant Programs. APPAP programs by specialty. Accessed at http://appap.org/Programs/tabid/58/Default.aspx on January 30, 2010.
[7] https://architectinperson.wordpress.com/2011/11/16/stop-calling-me-the-intern/
[vii] https://www.emra.org/be-involved/be-an-advocate/working-for-you/post-grad-statement-pa-np/, accessed 9/12/2020
[viii] https://med.dartmouth-hitchcock.org/pa-residency/ccappresidency.html

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system

of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations,

and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

H-275.925 Protection of the Titles "Doctor," "Resident" and "Residency"
Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO).
Sub. Res. 232, A-08; Reaffirmation I-09; Reaffirmed: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 09, A-19

D-160.995 Physician and Nonphysician Licensure and Scope of Practice
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and

(c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.
CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19

H-270.958 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners
1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.
2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.
BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16

D-35.996 Scope of Practice Model Legislation
Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners.
Res. 923, I-03Reaffirmed: BOT Rep. 28, A-13

H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Code of Medical Ethics: 10.5 Allied Health Professionals
Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being.
In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:
(a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
(b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.
(c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.
AMA Principles of Medical Ethics: I,V,VII

D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists
Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.
Res. 220, I-01Reaffirmed: CMS Rep. 7, A-11

D-275.979 Non-Physician "Fellowship" Programs
Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.
CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14

D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists
Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.
Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Establishing Minimum Standards for Parental Leave during Graduate Medical Education Training

Referred to: Reference Committee C

Whereas, A substantial number of trainees become parents during their training as a resident or fellow; and

Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a 12-month employment eligibility threshold; and

Whereas, Unlike other industries, such as technology and law, "there is no standardized approach to parental leave across GME programs" [1]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) does not establish minimum standards for duration of parental leave for trainees; and

Whereas, A lack of minimum national standards may result in some trainees receiving substandard resources and benefits[2]; and

Whereas, Current AMA policy (H-405.960) encourages residency programs, among other stakeholders, to incorporate a "six-week minimum leave allowance;" therefore be it

RESOLVED, That our American Medical Association support current efforts by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and align minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H-405.960 (Directive to Take Action); and be it further

RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue burden on trainees related to parental leave (Directive to Take Action); and be it further

RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows in good standing, who take maximum allowable parental leave, to complete their training within the original time frame. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. Specifically, the ACGME is actively working on this and not having AMA policy on an issue that affects a significant number of trainees while discussions are actively being had by decision makers makes this policy particularly relevant and timely. This policy applies to current and all future physician trainees.

References:
1. Vassallo P, Jeremiah J, Forman L, et al. Parental Leave in Graduate Medical Education: Recommendations for Reform. *Am J Med*. 2019;132(3):385-389. doi:10.1016/j.amjmed.2018.11.006
2. Baril N. Parenting during Graduate Medical Training — Practical Policy. 2019:995-997. doi:10.1056/NEJMp1902966

RELEVANT AMA POLICY

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the “Program Requirements.” The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution’s GME Committee must monitor programs’ supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (D) Other applicable Common

and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.
Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning

maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

Parental Leave H-405.954
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members. Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Updating Current Wellness Policies and Improving Implementation

Referred to: Reference Committee C

Whereas, Previous AMA-RFS policy asked our AMA to study resident burnout prevention and wellness strategies (291.015R); and

Whereas, This same policy was reaffirmed at I-18 (291.036R); and

Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) policy does include program requirements for specific aspects, but is unclear about what satisfies those requirements[1]; and

Whereas, New data exists regarding the efficacy of various specific burnout prevention strategies[2-7]; and

Whereas, Some organizations such as Stanford Medicine have been leaders in the field of physician wellness and burnout prevention through research, novel approaches and curriculum and support such as House Staff Wellbeing Panel and it may be prudent to apply these strategies into ACGME common requirements of residency programs[8]; and

Whereas, These specific strategies may be a more effective way to mitigate burnout than the current ACGME policy as listed; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council on Graduate Medical Education and other appropriate stakeholders in the creation of an evidence-based best practices reference to address trainee burnout prevention and mitigation. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

Although there is much focus on wellness in the era of COVID-19, this has been a long-standing concern for which too little has been done to affect change, and it is now taking its toll. Although this is less urgent due to the declining pandemic, medicine has struggled with how to address burnout and sustain wellness for years and there is no better place to begin to address this than at the GME level.

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1. “Common Program Requirements.” ACGME, Accreditation Council for Graduate Medical Education, https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements.
2. Mindfulness therapies on health professionals. Ruiz-Fernández MD, Ortíz-Amo R, Ortega-Galán ÁM, Ibáñez-Masero O, Rodríguez-Salvador MDM, Ramos-Pichardo JD. Int J Ment Health Nurs. 2019 Sep 9. doi: 10.1111/inm.12652. [Epub ahead of print] Review. PMID: 31498549
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4. Doctor, how can we help you? Qualitative interview study to identify key interventions to target burnout in hospital doctors. Walsh G, Hayes B, Freeney Y, McArdle S. BMJ Open. 2019 Sep 5;9(9):e030209. doi: 10.1136/bmjopen-2019-030209. PMID: 31492785
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7. The effects of playing music on mental health outcomes. Wesseldijk LW, Ullén F, Mosing MA. Sci Rep. 2019 Aug 30;9(1):12606. doi: 10.1038/s41598-019-49099-9. PMID: 31471550
8. https://wellmd.stanford.edu/

RELEVANT AMA POLICY

Code of Medical Ethics

9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse.

Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(JUN-21)

Introduced by: Pennsylvania

Subject: Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure

Referred to: Reference Committee C

Whereas, The 2020 registration fee for the United States Medical Licensing Exam (USMLE) Step 2 Clinical Skills (CS) exam is $1,300 (1); and

Whereas, The 2020 registration fee for the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 Performance Evaluation (PE) exam is $1,295 (9); and

Whereas, Students incur additional travel and lodging expenses to take the Step 2 Clinical Exam in one of five locations across the country or to take the COMPLEX Level 2 PE exam in one of two locations (2,10); and

Whereas, The average medical school debt for class of 2019 graduates in the United States (U.S.) was $201,490 (8); and

Whereas, The Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation ensure standards of clinical proficiency by students attending U.S.-accredited MD and DO programs, respectively (3,4); and

Whereas, Scores on USMLE Step 2 CS exams are not predictive of intern clinical skills performance (6); and

Whereas, There is a lack of data on usefulness USMLE Step 2 CS exam results provide (6); and

Whereas, USMLE Step 2 CS is a costly method of evaluating clinical skills and adds little value to the U.S. healthcare system (7); and

Whereas, Existing American Medical Association (AMA) policy, last affirmed in 2019, commits to working with appropriate stakeholders, including state medical boards, to replace USMLE Step 2 CS and COMLEX Level 2 PE exams (5); and

Whereas, Existing AMA policy commits to timely changes in the clinical skills examination process to reduce cost to medical students (5); and

Whereas, Existing PAMED policy supports the elimination of the USMLE Step 2 CS and COMLEX Level 2 PE exams, with the creation of standards for a clinical schools exam to be held at accredited medical or osteopathic schools (13); and

Whereas, These two examinations have been administratively suspended during the pandemic: USMLE Step 2 CS till June 2021 and COMLEX Level 2 PE till November 2020 (11,12); and

Whereas, Existing approaches for addressing this have focused on the Federation of State Medical Board (FSMB); and

Whereas, Advocacy targeting FSMB on this issue has not yielded resolution of this matter; and

Whereas, While the Covid pandemic has resulted in the cessation of both exams, at the present there is concern that as the pandemic eases one or both of these exams may be resurrected either in their previous form or in some new modified version in the near future; therefore be it

RESOLVED, That our American Medical Association work to rescind USMLE Step 2 CS and COMLEX Level 2 PE examination requirements and encourage a “fifty-state approach” by all individual state medical societies to engage with their respective state medical boards on this issue. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/21

AUTHOR’S STATEMENT OF PRIORITY

This resolution is listed as only a high priority and not a top priority since it’s impact is not on all physicians. Yet it is of top importance to those individuals for which these exams apply. The reason that this resolution is not reaffirmation is that this resolution seeks the AMA to approach this problem in a new direction. Working with individual state societies can help withdraw the sense that these exams are an appropriate evaluation criteria. Even if only 1/4 of the individual states withdraw this requirement from their individual state boards there will be increased pressure on other state boards to fall in line.

The question as to whether it is better to continue to have the AMA to continue to work from a top down approach on this and other issues will be determined by how easy and or successful we are with a decentralized “fifty state” approach that is coordinated and lead by the AMA

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2. https://www.csecassessments.org/test-centers/
3. https://lcme.org/about/
4. https://osteopathic.org/accreditation/accreditation-guidelines/
5. AMA policy as below, D-295.988
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RELEVANT AMA POLICY

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.
Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(JUN-21)

Introduced by: Pennsylvania

Subject: Supporting GME Program Child Care Consideration During Residency Training

Referred to: Reference Committee C

Whereas, Residency training often occurs during one's childbearing and child-rearing years while residents concurrently work long hours with unpredictable, demanding schedules, necessitating childcare for those residents who are parents, especially women (1); and

Whereas, On-site, extended-hour, and/or drop-in child care is desired by both male and female residents because it allows residents (a) more frequent contact with their children, (b) reduced stress and anxiety with scheduling of work and children's needs, and (c) decreased utilization of parental and/or FMLA leave policies, providing net financial benefit to the healthcare provider facility through tax benefits and increased resident productivity (2, 3, 4, 5, 6, 7); and

Whereas, Childcare costs are financially burdensome. In the northeast, the overall annual household cost of childcare was $24,815 in 2017 for a family with two children. In Pennsylvania, the cost of individual part-time center-based child care was $7,148 which is ranked as the highest in the nation and itself exceeds the 7% household child care expense share of income for residents and fellows – as recommended by the United States Department of Health and Human Services; this cost comes at a time when most residents also begin repayment of their cumulative higher education student loan debt which compounds the financial burdens faced by residents (8, 9, 10); and

Whereas, Childcare resources available to residents are inconsistent between graduate medical education residency program host institutions. A national survey of graduating pediatric residents found that only 24% reported access to on-site childcare at their training institution, 19% reported access to sick-child care, and 9% received subsidies for childcare expenses (11). In a survey of pediatrics department chairs, 59% indicated that on-site childcare or assistance with finding childcare was available at their institution for residents, but 50% responded that demand for childcare always or almost always exceeded availability (12). In a survey of general surgery program directors, 40% indicated on-site childcare at their facility with residents facing enrollment waiting lists and challenges scheduling for pick-up and drop-off (13). Similar findings have been recently described in a survey among obstetrics and gynecology residency program directors (14); and

Whereas, Childbearing and child-rearing responsibilities are disproportionately burdensome upon women in the United States, regardless of occupation (15); and

Whereas, Surgery residents who report perceiving stigma during pregnancy practiced at institutions that did not have a formal institutional maternal leave policy or were required to alter training plans (16); and

Whereas, Supportive childcare policies may enable more equity for female physician career advancement and contribute to a wider variety of specialty choices. In a study conducted at Stanford University School of Medicine, female physicians ranked flexible working environments – with particular regard to childcare, including emergency childcare on-site or nearby – as the highest priority and most important need to improve their career success and well-being (17). Likewise, in a survey of general surgery residency program directors, 61% of directors indicated that having children negatively affects female trainees' work and places an increased burden on colleagues (18); therefore be it

RESOLVED, That our American Medical Association convene a group of interested stakeholders to examine the need for innovative childcare policies and flexible working environments for all residents in order to promote equity in all training settings. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Pennsylvania Delegation would appreciate the committee considering its Resolution A-20, "Supporting GME Program Child Care Consideration During Residency Training," to be "Medium Priority" for the upcoming June HOD. There is a marked overlap between the usual residency training period and the optimal years for childbearing and rearing. Residents are often faced with not only long and demanding work schedules but childcare costs that are financially burdensome and often occur simultaneous with the repayment of student loans. Further, these responsibilities often fall disproportionately on female residents and resources available to residents are inconsistent and often inadequate. Supportive policies for childcare will promote greater equity, inclusion and career advancement for females in all GME programs as reflected in a study from Stanford. As an example of educational needs for training programs, a recent survey of program directors in general surgery residencies noted that, "having children negatively affects female trainees' work and places and increased burden on colleagues". This stigmatizing of female trainees is not only traumatizing to the trainees but also sets a terrible example for others. We believe that it is in the best interest of the AMA as well as US medicine to address this important topic now and work diligently to remove this unnecessary burden on our junior colleagues.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(JUN-21)

Introduced by: Pennsylvania

Subject: Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine (ABIM)

Referred to: Reference Committee C

Whereas, Our American Medical Association has noted the heavy financial and emotional toll that the Maintenance of Certification (MOC) programs of some of the American Board of Medical Specialties Boards (ABMS) have had on physicians; and

Whereas, Many physicians are certified by more than one ABMS Board but participate in MoC with only one of those boards, and

Whereas, The ABIM, while recognizing that some ABIM certified physicians hold and maintain board certification by a board other than the ABIM, and

Whereas, The ABIM charges such physicians a fee which is nearly as high as that charged physicians maintaining certification with the ABIM, and

Whereas, The ABIM refuses to accurately reflect such physicians' status as "Participating in MOC" in the ABIM Directory unless they pay that fee, therefore be it

RESOLVED, That our American Medical Association work with the American Board of Medical Specialties Boards (ABMS), in general, and American Board of Internal Medicine (ABIM), specifically, to require the ABIM stop charging physicians with two or more board certifications, who participate in Maintenance of Certification (MOC) with a board other than the ABIM, a fee to accurately list their current board status in the ABIM Directory. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Over the last several sessions our AMA has been presented issues of MOC and recertification. This resolution focuses on issues of multiple board certifications, expenses of certification and discrepancies with accurately listing of physician status by the ABMS and the ABIM specifically.

The resolution asks that the AMA stop the ABMS and the ABIM from multiple charges for physicians with more than one board certification and to have the ABIM accurately list a physician participating in MOC with other boards and list their board status as such without paying full fee to the ABIM.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(JUN-21)

Introduced by: Illinois

Subject: Student Loan Forgiveness

Referred to: Reference Committee C

Whereas, The cost of medical education, all facets included, is a significant burden for resident physicians as well as for young physicians beginning practice; and

Whereas, Such costs and burdens significantly influence medical specialty and location of practice selection and it is widely thought that this limits the numbers of students selecting primary care specialties; and

Whereas, The Public Service Loan Forgiveness Program, a federal program, allows payment for 10 years against the loan balance then the application for loan forgiveness of the remaining loan amounts at that point; and

Whereas, 98% of applications for loan forgiveness under the Public Service Loan Forgiveness Program are denied; therefore be it

RESOLVED, That our American Medical Association study the cause for the unacceptably high denial rate of applications made to the Public Health Services Student Loan Forgiveness Program, and advocate for improvements in the administration and oversight of the Program, including but not limited to increasing transparency of and streamlining program requirements; ensuring consistent and accurate communication between loan services and borrowers; and establishing clear expectations regarding oversight and accountability of the loan servicers responsible for the program. (Directive to Take Action)

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

Received: 05/11/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHOR'S STATEMENT OF PRIORITY

This resolution reflects an issue that is both urgent and high priority. Medical school debt loads are reaching crisis levels, and the high cost of medical education is significantly impacting the size and distribution of the physician work force. The Public Health Services Student Loan Forgiveness program was supposed to be a lifeline for medical students, but the denial rates under the program have been astronomical, clearly an indication of poor communication and implementation of program requirements. It is critical that this issue be addressed as soon as possible so that students who adhere to the service requirements of program are able to access the loan terms they were promised.

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https://students-residents.aamc.org/financial-aid/article/public-service-loan-forgiveness-pslf/
https://www.nytimes.com/2019/11/28/us/politics/student-loan-forgiveness.html

RELEVANT AMA POLICY

H-305.925 - Principles of and Actions to Address Medical Education Costs and Student Debt

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

…

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the

interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

…

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19 Appended: Res. 316, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(JUN-21)

Introduced by: American College of Preventive Medicine
American College of Occupational and Environmental Medicine
American Association of Public Health Physicians

Subject: AMA Support for Increased Funding for the American Board of Preventive Medicine (ABPM) Residency Programs

Referred to: Reference Committee C

Whereas, The AMA mission statement supports the betterment of public health; and

Whereas, The American Board of Preventive Medicine is the Board responsible for certification of the skills, knowledge and professional acumen of physicians in specialties of Aerospace Medicine, Occupational and Environmental Medicine, and Public Health & General Preventive Medicine, and subspecialties including Undersea & Hyperbaric Medicine, Medical Toxicology, Clinical Informatics and Addiction Medicine; and

Whereas, These specialties and subspecialties are the core residencies of training for future public health physicians and leaders in this country; and

Whereas, The COVID-19 pandemic has clearly emphasized the imperative for trained public health leadership to ensure proper preparedness and response in the US; and

Whereas, The COVID-19 pandemic has raised the awareness of a shortage of physician trained to address prevention, preparedness, response, recovery, and resiliency in rural communities across America; and

Whereas, Funding support for preventive medicine specialties is not generally understood nor offered through traditional sources from the Centers for Medicare and Medicaid Services (CMS); and

Whereas, Variable funding comes from Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), National Institutes of Occupational Safety and Health (NIOSH) and the Defense Act; and

Whereas, These residency programs continually lack sufficient funding to fill the slots available and financially support the training for this important aspect of the health care workforce; therefore be it

RESOLVED, That our American Medical Association support and advocate for increased funding through the Health Resources and Services Administration (HRSA), National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC), and other mechanisms for all residencies training physicians in the Preventive Medicine specialties of Aerospace Medicine, Occupational and Environmental Medicine and Public Health & General Preventive Medicine, and subspecialties including Undersea & Hyperbaric Medicine, Medical Toxicology, Clinical Informatics and Addiction Medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA actively increase further awareness of the importance of public health training, leadership, and principles among all medical students and physicians in training and in practice. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We are public health. We are the Section Council on Preventive Medicine (SCPM), the conscience of public health in the American Medical Association (AMA) House of Delegates. The mission of AMA includes the betterment of public health in this country and we need to do a better job emulating, supporting and advancing this important work.

The severity of the covid-19 pandemic clearly uncovered the deficits and deficiencies of the public health system in response to this crisis. The threat continues even as we meet for the AMA annual meeting. One of the important and pressing deficits in the US system is the lack of a strong cadre of medical leaders in the public health system. Preventive medicine specialties are the areas in medicine where physicians receive appropriate training in public health matters. Good medical leadership is critical for the foundation of the public health infrastructure. Residencies in preventive medicine specialties are disappearing due to necessary funding sources. The AMA as the voice of medicine in this country can sound the alarms now about this pressing need. In doing so, the AMA would be meeting its mission of the betterment of public health.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(JUN-21)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee C

Whereas, During the COVID-19 pandemic, physicians have been on the front lines, and have experienced increased duress and extreme fatigue during the case surges as hospitals are overrun with patients; and

Whereas, Longer shifts, disruptions to sleep and to work-life balance, and occupational hazards associated with exposure to COVID-19 have contributed to physical and mental fatigue; and

Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as shift work disorder;[5] and

Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property damage-only crashes;[2] and

Whereas, Physicians have a higher likelihood of dying from accidents than from other causes relative to the general populations;[4] and

Whereas, Physicians' risk of crashing while driving after working extended shifts (≥24 hours) was 2.3 times greater and the risk for a "near miss" crash was 5.9 times greater, compared to a non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional extended work shift hour;[3] and

Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night shift;[6] and

Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without sleep;[7] and

Whereas, Driving simulator studies show driving home from the night shift is associated with two to eight times the incidents of off track veering, decreased time to first accident, increased eye closure duration, and increased subjective sleepiness. Night-shift work increases driver drowsiness, degrading driving performance and increasing the risk of near-crash drive events;[8] and

Whereas, Actual driving studies post-night shift versus post-sleep night showed eleven near-crashes occurred in 6 of 16 post night-shift drives (37.5 percent), and 7 of 16 post night-shift drives (43.8 percent) were terminated early for safety reasons, compared with zero near-crashes or early drive terminations during 16 post-sleep drives;[9] and

Whereas, AMA Policy H-15.958, "Fatigue, Sleep Disorders, and Motor Vehicle Crashes," notes the risks associated with sleep deprivation and actions physicians can take to help protect patients; therefore be it

RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further

RESOLVED, That the AMA advocate for policies that support fatigue mitigation programs, which include, but are not limited to, quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

COVID fatigue has been used to describe the intense and overwhelming fatigue, irritability and disorientation experienced by physicians and healthcare workers during the pandemic. The high patient volumes and extra shifts during surges place additional physiologic strain on physicians. It is important for that the AMA advocate for policies that support fatigue mitigation programs and make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being.

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RELEVANT AMA POLICY

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of

professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.
Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958
Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups
(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.
(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
(8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(JUN-21)

Introduced by: Medical Student Section

Subject: Standard Procedure for Accommodations in USMLE and NBME Exams

Referred to: Reference Committee C

Whereas, The Americans with Disabilities Act (ADA) section 36.309 requires that any documentation requested by a testing entity in order to evaluate a request for testing accommodations be both reasonable and limited to only the information needed to determine the nature of a candidate's disability and their need for the requested testing accommodations[1]; and

Whereas, Under ADA section 36.309, examples of legally-appropriate accommodation request documents include: (1) recommendations by qualified healthcare professionals, (2) proof of past testing accommodations, (3) observations by educators, (4) results of psycho-educational or other professional evaluations, (5) an applicant's history of diagnosis, and (6) an applicant's statement of his or her history regarding testing accommodations[1]; and

Whereas, Under ADA section 36.309, depending on the nature of either the disability, or the form of requested accommodation, a testing entity might only need one or two forms of documentation to verify the nature of the candidate's disability and his or her need for the requested accommodation[1]; and

Whereas, Under ADA section 36.309, proof of past testing accommodations in similar test settings is generally sufficient to support a request for the same testing accommodations for a subsequent standardized exam or other high stakes test[1]; and

Whereas, Under ADA section 36.309, if a candidate previously received testing accommodations under an Individualized Education Program (IEP) or Section 504 Plan, they should generally receive the same testing accommodations for a subsequent standardized exam, with examples including extra time, additional or extended breaks, testing in a private room, or other sight- or hearing-based accommodation[1,2]; and

Whereas, Under ADA section 36.309, recognizing the importance of face-to-face evaluation for a correct diagnosis, directs testing entities to give precedence to reports from qualified professionals who have personally evaluated the candidate over reports from testing entity reviewers who did not conduct an assessment of the candidate for diagnosis and treatment[1]; and

Whereas, The National Board of Medical Examiners (NBME) has a practice of reviewing and sometimes denying accommodations requests without a face-to-face evaluation[1,3]; and

Whereas, In *Berger v. the National Board of Medical Examiners*, the NBME denied an accommodation request based on the testimony of NBME-paid outside experts who provided their opinions without having evaluated the candidate[1,3]; and

Whereas, This practice violates the ADA's requirement of deference to the opinions based on in-person evaluations[1,3]; and

Whereas, ADA section 36.309, states a qualified professional's decision not to provide results from a specific test or evaluation instrument should not preclude approval of a request for testing accommodations where the documentation provided by the candidate, in its entirety, demonstrates that the candidate has a disability and needs a requested testing accommodation[1]; and

Whereas, According to ADA section 36.309, a testing entity must respond in a timely manner to requests for testing accommodations, including when that entity requests additional information, to ensure equal opportunity for applicants with disabilities to register and take the test in the same testing cycle as their classmates as to not delay their medical education[1]; and

Whereas, According to ADA section 36.309, failure by a testing entity to act in a timely manner, coupled with requests for duplicative, unnecessary, or extraneous documentation, could result in an extended delay such that it denies persons with disabilities equal opportunity or equal treatment as their peers without disabilities[1]; and

Whereas, American College Testing (ACT), which administered the ACT to approximately 1.91 million students in 2018, states that requests are normally processed in 10-14 business days[4,5]; and

Whereas, The Law School Admission Council (LSAC), which administered the Law School Admission Test (LSAT) to 138,597 students between June of 2018 and March of 2019, states that students who request the same accommodations that they have received previously will receive those accommodations without further documentation, as long as they provide verification of that previous accommodation for a standardized test and the accommodation does not require administration over multiple days[6,7]; and

Whereas, The United States Medical Licensing Examination (USMLE) website states that the applicant should wait 60 days for processing and requires a personal statement, complete and comprehensive evaluation from a qualified professional done in the past three years, and supporting documentation potentially including academic records, score transcripts for previous standardized exams, verification of prior academic/test accommodations, relevant medical records, previous psychoeducational evaluations, faculty or supervisor feedback, job performance evaluations, and course evaluations[2,8,9]; and

Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education, a book which is written for health science administrators and disability service providers, recommends beginning the accommodation request process 10 months before the planned exam date due to the rigor of completing the appropriate documentation coupled with the time needed for processing and approval [2]; and

Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education states that the assessments students often need to qualify for accommodations cost between $1,200 to more than $5,000 dollars depending on health insurance and geographic location[2]; and

Whereas, A study by the Association of American Medical Colleges and the Human Resources Research Organization found that medical students who received extended time on the Medical College Admission Test (MCAT) had no difference in either MCAT scores or in rates of

admission to medical school, and even after they controlled for undergraduate GPA, the students who had received MCAT accommodations had between 8.1% to 18.9% lower graduation rates based on the number of years it took to graduate and an 11%, 9%, and 5% lower pass rate on Steps 1, 2 CK, and 2 CS respectively[10]; therefore be it

RESOLVED, That our American Medical Association collaborate with medical licensing organizations to facilitate a timely accommodations application process (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The issue of equitable access and disabilities is a priority for our delegation. This resolution touches on the heart of an issue not often considered for physicians: representation of all abilities. Both schools' technical requirements and the strict processes of NBME deter students with disabilities from becoming physicians. NBME requirements are even more stringent and difficult for students with temporary disabilities or new-onset disability, as it is difficult to prove "previous accommodations" on short notice given the timeline of requesting accommodations.

We believe that the asks of this resolution to standardize and improve the accommodations of medical students with disabilities to be salient. Although not officially recognized by the AAMC as underrepresented in medicine, persons with disabilities represent 0.3-2.7% of medical students and practicing physicians compared to 19.4% of US citizens. Medical students and physicians with disabilities provide high quality and culturally competent care to a diverse patient population, but are met by many barriers to practicing medicine. A standardized process to accommodations for licensing exams would be an appropriate step to addressing these barriers to practice.

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RELEVANT AMA POLICY

Accommodating Lactating Mothers Taking Medical Examinations H-295.861
Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. (Sub Res. 903, I-14; Modified Res. 310, A-17)
Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. (CME Rep. 1, I-06, Reaffirmed: CME Rep. 7, A-08, Reaffirmed: CCB/CLRPD Rep. 4, A-13, Modified: CME Rep. 01, A-16, Reaffirmation: A-16)

Advocacy for Physicians with Disabilities D-90.991
1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities. (Res. 617, A-19)

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws. (Res. 220, I-17)

Enhancing Accommodations for People with Disabilities H-90.971
Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines. (Res. 705, A-13)

A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities D-295.929
Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates with disabilities and challenges to employment after training. (Res. 317, A-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(JUN-21)

Introduced by: Medical Student Section

Subject: Representation of Dermatological Pathologies in Varying Skin Tones

Referred to: Reference Committee C

Whereas, Worse healthcare outcomes result from the under recognition of dermatologic pathologies, such as erythema migrans and the late detection of melanoma in individuals with darker skin tones – also known as Fitzpatrick skin types III-VI[1-4]; and

Whereas, There is a higher probability that individuals with darker skin tones have late detection of disease when compared to lighter skin tones (Fitzpatrick skin types I-II)[5-8]; and

Whereas, There is a lack of targeted skin cancer awareness and prevention efforts for patients with darker skin tones[9] resulting in lower rates of skin cancer screening; and

Whereas, Research has demonstrated that patients with darker skin tones feel frustrated when dermatologists do not demonstrate competency recognizing and treating pathologies on darker skin[10]; and

Whereas, It has been shown that overrepresentation of minority group skin tones relative to their proportion in the population is required to achieve equitable diagnostic outcomes[11-13]; and

Whereas, About 75 percent of dermatological imagery in medical textbooks represent individuals with lighter skin tones while core dermatology textbooks used to educate trainees, dermatologists, and generalists have limited representations of skin of color[14]; and

Whereas, Terms such as “Classic Presentation” are usually examples of lighter skin tones[15]; and

Whereas, Although our AMA recognizes the importance of racial and ethnic disparities in healthcare (H-350.974), the terms “race” and “ethnicity” are not equivalent nor interchangeable with the genotypic and phenotypic characteristics of “skin tone”[16-18]; and

Whereas, Existing AMA policy “promote[s] education on the importance of skin cancer screening and skin cancer screening in patients of color” (H-55.972) but lacks policy to ensure medical students are adequately primed to recognize such pathologies in a variety of skin colors; and

Whereas, While current AMA policy supports ensuring diversity in United States Medical Licensing Examination exam test/oversight committees representative of the test takers (D-275.963), this policy does not cover diversity in test questions themselves, nor the importance of skin tone as a relevant pathological factor missing in dermatological exam questions; therefore be it

RESOLVED, That our American Medical Association encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the development of educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones (New HOD Policy); and be it further

RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation believes that this expands upon existing AMA priorities on race in medicine and medical education. Our colleagues have shared anecdotes on the paucity of pathologies presented on various skin tones, making the recognition of even "simple" skin diagnoses or clinical findings more challenging. That lack of exposure to presentations of various skin tones or awareness of their preconceived biases in this realm can further misdiagnoses or missed diagnoses. Dearth in knowledge of this increases risk for misdiagnosis in patients and shows another example of how disparities in healthcare occur.

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RELEVANT AMA POLICY

Early Detection and Prevention of Skin Cancer H-55.972
Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.
CCB/CLRPD Rep. 3, A-14

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.
CME Rep. 11, A-06, Reaffirmation A-11, Modified in lieu of Res. 908, I-14, Reaffirmed in lieu of Res. 306, A-15, Reaffirmed: BOT Rep. 39, A-18, Modified: CME Rep. 01, A-20

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians

to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19

Ensuring Diversity in United States Medical Licensing Examination Exams D-275.963
Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers.
Sub. Res. 306, A-09, Reaffirmed: CME Rep. 01, A-19

Continued Support for Diversity in Medical Education D-295.963
1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
Res. 325, A-03, Appended: CME Rep. 6, A-11, Modified: CME Rep. 3, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(JUN-21)

Introduced by: Medical Student Section

Subject: Improving Support and Access for Medical Students with Disabilities

Referred to: Reference Committee C

Whereas, The Americans with Disabilities Act (ADA) defines a disability as “a physical or mental impairment that substantially limits one or more major life activities of an individual; a record of such an impairment; or being regarded as having such an impairment”[1,2];and

Whereas, In enacting the Americans with Disabilities Act, “Congress recognized that physical and mental disabilities in no way diminish a person’s right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers”[1]; and

Whereas, Research has found that concordances between patient and physician’s race and ethnicity significantly enhanced the patient's healthcare experience, compliance and outcomes, yet little has been done to ensure the same for patients with disabilities[3,4]; and

Whereas, Patients with disabilities feel their doctors who don't have disabilities do not understand the realities of their struggles, yet barriers persist in preventing people with disabilities from entering the medical profession[5,6]; and

Whereas, People with disabilities comprise about a quarter of the US adult population, but only 5 percent of medical students and 2 to 10 percent of practicing physicians[6-10]; and

Whereas, Medical school applicants and students may not be aware that they qualify for protection based on the broader definition of disability in the ADA or may be discouraged from disclosing an existing or newly arising disability due to fear of discrimination in admissions or licensure[11-13]; and

Whereas, Section 504 of the Rehabilitation Act states that, at the postsecondary level, institutions are “required to provide students with appropriate academic adjustments and auxiliary aids and services that are necessary to afford an individual with a disability an equal opportunity to participate in a school's program”[14]; and

Whereas, Accrediting bodies, including but not limited to the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA), have not established a uniform list of essential abilities and technical standards or requirements for reasonable accommodations in medical school or residency[15-17]; and

Whereas, This lack of standardized guidelines directly impacts a medical school’s understanding of accommodations, assistive technology, acceptable use of intermediaries, alternative learning experiences, and individualized assessment of disability under current law[15-17]; and

Whereas, Studies have shown that as many as 49 percent of the medical schools did not clearly state accommodation policies, many accommodation policies were difficult to locate, and some schools provided no information whatsoever, making them non-compliant with Section 504 of the Rehabilitation Act[17-19]; and

Whereas, A recent study showed that most medical school technical standards do not support the provision of reasonable accommodations for students with disabilities as intended by the ADA (e.g., proscribing intermediaries and auxiliary aids for hearing, vision, and mobility disabilities)[19]; and

Whereas, Hearing loss is the most common physical and sensory disability encountered in medical schools, with accommodations ranging from sign language interpreters to stethoscopes that amplify heart and lung sounds, but closed captions, which provide full and equitable access to video content to individuals with hearing loss, are not a standard option[20,21]; and

Whereas, Closed captions translate spoken language into written language and provide helpful clues to the person reading them by also identifying the person speaking, describing sound effects, and giving other relevant information[22]; and

Whereas, Closed captioning services are simple and inexpensive to implement through software that supports real time voice-to-text transcription to automatically caption videos[23]; and

Whereas, Although closed captions were originally designed to aid individuals who were deaf or hard-of-hearing, a meta-analysis of over 100 studies has shown that captions benefit student learners regardless of disability status by improving retention and comprehension (including those who are watching videos in a non-native language)[22-25]; and

Whereas, Existing AMA policies support improving access and support for clinicians, learners, and patients with disabilities (e.g., H-350.978, H-200.951, H-90.987, H-90.971, D-295.963); and

Whereas, Our AMA plays an existing role in developing policy and initiatives related to improving undergraduate medical education, including but not limited to the Accelerating Change in Medical Education Initiative, which has already begun to investigate meeting disability-related needs[26]; and

Whereas, Improving support and access for medical students and physicians with disabilities can improve patient care, impact research agendas and workplace attitudes toward disability, and reduce the significant barriers to health care, discrimination, and ableism experienced by people with disabilities[3,27-32]; therefore be it

RESOLVED, That our American Medical Association amend policy D-295.929 by addition to read as follows:

D-295.929 – A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES WITH DISABILITIES
Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees and students with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates and students with disabilities and challenges to employment after training and medical education; and 3) work with relative stakeholders to encourage medical education institutions to make their policies for inquiring about and obtaining accommodations related to disability transparent and easily accessible through multiple avenues including, but not limited to, online platforms. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy D-90.991 by addition and deletion to read as follows:

D-90.991 – ADVOCACY FOR PHYSICIANS WITH DISABILITIES
1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians and medical students with disabilities including but not limited to: (a) enhancing representation of physicians and medical students with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians and medical students with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians and medical students with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians, ~~and~~ physicians-in-training, and medical student education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical school communications, including but not limited to lecture recordings, videos, webinars, and audio recordings, that may prohibit any students from accessing information. (Directive to Take Action)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Medical trainees with disability graduate medical school at a significantly lower rate than trainees without disability, despite meeting the medical school physical/intellectual requirements for admission. These trainees experience significant barriers to receiving accommodations, including lack of access to proper care and evaluation, lack of approval of accommodations, stigma of accommodations, and a need to spend precious study time self-advocating and learning the legal framework. Medical trainees with disability spend many hours a week managing disability and advocating from it, which detracts from their ability to spend time on medical school. In order to minimize the amount of time spent on advocating for accommodations and pushing for administration to respond, systemic access should be promoted to accommodate all individuals pursuing medical studies.

Medicine is not a field that is accommodative of individuals not in perfect health, despite being a field that tries to serve such populations. This has been shown time and time again when NBME has received litigation for violating Americans with Disabilities Act. In 2020, NBME had 2 lawsuits brought forth against it for ADA violations. In the light of the COVID pandemic, disability rights in education have been further infringed upon, making this resolution timely and in line with AMA priorities to promote health equity for all individuals, including medical trainees pursuing their careers as physicians.

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RELEVANT AMA POLICY

Discrimination B-14
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.

Civil Rights & Medical Professionals 9.5.4
Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.
Issued: 2016

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A_16; Reaffirmation: A-16

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
CME Rep. 1, I-06; Reaffirmation: I-10; Reaffirmation: A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19

Equal Access for Physically Challenged Physicians H-90.987
Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.
Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.
Res. 220, I-17

Diversity in the Physician Workforce and Access to Care D-200.982
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.
CME Rep. 7, A_08; Reaffirmation: A-13; Reaffirmation: A-16

Creating an Effective Environment for Medical Student Education H-295.900
1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.
2. Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.
CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.
CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.
A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic

community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.
Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.
BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

Insurance Coverage for Medical Students and Resident Physicians H-295.942
The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.
BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14

Due Process H-295.998
(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: “A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and ‘due process’ must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights.”
(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and

written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.
CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20

Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945
The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.
BOT Rep. 1, I-93; CME Rep. 10, I-94; Reaffirmed: CME Rep. 2, A_04; Reaffirmed: CME Rep. 2, A-14

Continued Support for Diversity in Medical Education D-295.963
1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Enhancing Accommodations for People with Disabilities H-90.971
Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
Res. 705, A-13

Remediation Programs for Physicians D-295.325
1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level.
2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care.
3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians.

4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.
5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians.
CME Rep. 3, A-09; Reaffirmed: CME Rep. 01, A-19

Medical Staff Development Plans H-225.961
1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of .patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.
2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.
BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation: A-10; Modified: CMS Rep. 01, A-20

Reference Committee D

BOT Report(s)

10 Protestor Protections

15 Removing Sex Designation from the Public Portion of the Birth Certificate

16 Follow-up on Abnormal Medical Test Findings

CSAPH Report(s)

01* Council on Science and Public Health Sunset Review of 2011 House Policies

03* Addressing Increases in Youth Suicide

Resolution(s)

401 Universal Access for Essential Public Health Services

402 Modernization and Standardization of Public Health Surveillance Systems

403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America

404* Support for Safe and Equitable Access to Voting

405* Traumatic Brain Injury and Access to Firearms

406* Attacking Disparities in Covid-19 Underlying Health Conditions

407* Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities

408* Screening for HPV-Related Anal Cancer

409* Weapons in Correctional Healthcare Settings

410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis

411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens

412* Addressing Maternal Discrimination and Support for Flexible Family Leave

413* Call for Increased Funding and Research for Post Viral Syndromes

414* Call for Improved Personal Protective Equipment Design and Fitting

415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles

416* Expansion on Comprehensive Sexual Health Education

417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925

418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV

419* Student-Centered Approaches for Reforming School Disciplinary Policies

** Contained in the Handbook Addendum*

REPORT 10 OF THE BOARD OF TRUSTEES (June 2021)
Protester Protections
(Resolution 409-NOV-20)
(Reference Committee D)

EXECUTIVE SUMMARY

Background: The right of people to peaceably assemble is protected by the First Amendment to the Constitution. However, this right is not without limitation, as jurisdictions have a duty to maintain public order and safety and may regulate the time, place, and manner of protests. The use of force by law enforcement officers may be necessary and is permitted in certain circumstances. However, law enforcement officers should use only the amount of force necessary to mitigate an incident, make an arrest, or protect themselves or others from harm. Crowd control tactics used by law enforcement at some anti-racism protests have been called a public health threat, with excessive use of force raising health and human rights concerns as well as undermining freedom of peaceful assembly. Concerns have specifically been raised regarding law enforcement's use of crowd-control weapons (CCWs) or less-lethal weapons (LLWs), including kinetic impact projectiles (KIPs) and chemical irritants against protesters resulting in preventable injury, disability, and death.

Discussion: Population-level data on protest-related injuries from LLW, including chemical irritants and KIPs, are not readily available. Limited studies have attempted to identify these injuries through emergency department encounters captured through the injury surveillance systems as well as through injuries reported through traditional and social media. A systematic review of the literature on deaths, injuries, and permanent disability from KIPs from January 1990 to June 2017 identified injury data on 1,984 people. Over the 27-year period, 53 people (3 percent) died because of their injuries. Penetrative injuries caused 56 percent of the deaths, while blunt injuries caused 23 percent, head and neck trauma accounted for nearly 50 percent of deaths, and chest and abdominal trauma accounted for 27 percent. A systematic review found that among 9,261 injuries from chemical irritants, 8.7 percent were severe, two were lethal, and 58 caused permanent disabilities. Studies have identified chronic bronchitis, compromised lung function, and acute lung injury as consequences of chemical irritant exposure.

Conclusion: The right of assembly plays a fundamental role in public participation in democracy, holding governments accountable, expressing the will of the people, and in amplifying the voices of people who are marginalized. The morbidity and mortality data available on the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, suggests that their use by law enforcement for the purposes of crowd control and management should be prohibited in the United States. There is some data available to suggest that the use of LLWs decreases the likelihood of suspect injury, which is why a complete ban of all KIPs and chemical irritants is not recommended at this time. While it is important to recognize that there may be a role for the use of LLWs by law enforcement, standards for their use should be clear. If KIPs and chemical irritants are going to be used, law enforcement agencies should have specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries. Appropriate de-escalation techniques should be used to minimize the risk of violence when feasible. Where force is necessary to achieve a legitimate law enforcement objective, precautionary steps should be taken to minimize, the risk of injury or death.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-JUN-21

Subject:	Protester Protections (Resolution 409-NOV-20)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee D

At the November 2020 Special Meeting of the House of Delegates Resolution 409, introduced by the Medical Student Section, was referred for study. This resolution asked that our American Medical Association (AMA):

(1) advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States (Directive to Take Action); and
(2) encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm. (Directive to Take Action)

BACKGROUND

In 2020, protests and demonstrations increased in the United States following the outrage and grief over the killing of George Floyd, Breonna Taylor and other victims of law enforcement-related violence and racism across the country. While an analysis of more than 7,750 demonstrations across the country from May 26, 2020 through August 22, 2020 found that more than 93 percent of Black Lives Matter protests have been peaceful, a small number of protests involved demonstrators engaging in violence.[1] Crowd control tactics used by law enforcement at some anti-racism protests have been called a public health threat, with excessive use of force raising health and human rights concerns as well as undermining freedom of peaceful assembly.[2,3] Concerns have specifically been raised regarding law enforcement's use of crowd-control weapons (CCWs) or less-lethal weapons (LLWs) against protesters resulting in preventable injury, disability, and death.[3]

The right of people to peaceably assemble is protected by the First Amendment to the Constitution. However, this right is not without limitation, as jurisdictions have a duty to maintain public order and safety and may regulate the time, place, and manner of protests. The use of force by law enforcement officers may be necessary and is permitted in certain circumstances. However, law enforcement officers should use only the amount of force necessary to mitigate an incident, make an arrest, or protect themselves or others from harm.[4]

The American Medical Association has previously studied the issue of law enforcement-related violence. This report will be narrowly focused on the issue of the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States.

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DEFINITIONS

Definitions are critically important to this issue. For the purposes of this report, key terms are defined as follows:

Crowd control is defined as techniques used to address civil disturbances (breach of the peace or an assembly where there is a threat of violence, destruction of property, or other unlawful acts), to include a show of force, crowd containment, dispersal equipment and tactics, and preparations for multiple arrests.[5]

Crowd management is defined as techniques used to manage lawful assemblies (demonstrations, marches, or protests) before, during, and after the event for the purpose of maintaining lawful status through event planning, pre-event contact with event organizers, issuance of permits when applicable, information gathering, personnel training, and other means.[5]

Demonstrations are defined as the lawful assembly of persons organized primarily to engage in free speech activity. These may be scheduled events that allow for law enforcement planning. However, lawful demonstrations can devolve into civil disturbances that necessitate enforcement actions.[5]

Kinetic impact projectiles (KIPs), commonly called rubber or plastic bullets, are defined as projectiles designed and intended to deliver non-penetrating impact energy. KIPs are designed to incapacitate individuals by inflicting pain or sublethal injury.[3] Some KIPs target an individual with a single projectile, while others target a group by scattering multiple projectiles. There are numerous types of KIPs available, including "rubber bullets," which are spherical or cylindrical projectiles and can be made of hard rubber, plastic, or polyvinylchloride. The term "rubber bullets" is also often used to describe KIPs made of a composite of plastic and metal fragments as well as metal bullets surrounded by a coating of plastic or rubber.

Chemical irritants, also referred to as riot control agents, are chemical compounds that temporarily make people unable to function by causing irritation to the eyes, mouth, throat, lungs, and skin.[6] Several different chemical compounds are used as chemical irritants, including oleoresin capsicum ("pepper spray"), hexachloroethane ("smoke grenade"), the "tear gases" chloroacetophenone, chlorobenzylidenemalononitrile (CS), chloropicrin, bromobenzylcyanide, dibenzoxazepine, as well as combinations of various agents. Chemical irritants come in many forms (liquids, solids, fine powders), thus many formulations and dispersion technologies are used. Most are released into the air as fine droplets or particles using propellants, solvents, or explosives.

EXISTING AMA POLICY

Existing AMA policy does not address the use of chemical irritants or kinetic impact projectiles for crowd control. Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," encourages the study of the public health effects of physical or verbal violence between law enforcement officers and the public, particularly within ethnic and racial minority communities; encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement; supports requiring the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies; and encourages appropriate stakeholders, to define "serious injuries" for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Tasers, or Conducted Electrical Devices (CEDs) are another LLW often used by law enforcement. The AMA has existing policy on CEDs, which recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for their use that is modeled after available national guidelines. CEDs are outside of the scope of this report.

DISCUSSION

Population-level data on protest-related injuries from LLW, including chemical irritants and KIPs, are not readily available. There are limited regulations on the development of KIPs and manufacturers are not required to keep records on injuries from their products. Generally, there is no requirement for law enforcement to collect data on injuries from LLWs and if the data is collected, it may not be publicly available. Limited studies have attempted to identify these injuries through emergency department encounters captured through the injury surveillance systems as well as through injuries reported through traditional and social media. While research has shown that people of color face a higher likelihood of being killed by police than do White men and women[7], morbidity and mortality specific to LLWs and their use in crowd control by race and ethnicity is unclear. Though it has been observed that crowds comprised largely of people of color have faced a more aggressive, more militarized approach.[8]

Law enforcement agencies oppose some restrictions on LLWs, saying the weapons are a critical tool to control uncooperative people that stops short of deadly force. Limiting access to LLWs could increase morbidity and mortality, requiring law enforcement officials to choose a more deadly form of force. There is some data available to suggest that the use of LLW decreases the likelihood of suspect injury.[9,10] For example, the use of pepper spray decreased the likelihood of suspect injury by 65 percent.[11] However, most of this research is focused on CEDs and pepper spray and is not specific to KIPs or crowd control.

Injury, Disability, and Death from Kinetic Impact Projectiles (KIPs)

A systematic review of the literature on deaths, injuries, and permanent disability from KIPs from January 1990 to June 2017 identified injury data on 1,984 people.[3] Over the 27-year period, 53 people (3 percent) died because of their injuries. Penetrative injuries caused 56 percent of the deaths, while blunt injuries caused 23 percent, head and neck trauma accounted for nearly 50 percent of deaths, and chest and abdominal trauma accounted for 27 percent.[3] Three hundred people (15 percent of survivors) suffered permanent disability. Many injuries were secondary to vision loss and abdominal injuries resulting in splenectomies or colostomies. Amputation of a limb occurred in two individuals.[3] Of the 2,135 injuries in the 1,931 people who survived, 71 percent were severe, with injuries to the skin and extremities being the most frequent.[3] Almost all (91.5 percent n=732) head and neck, ocular, nervous, cardiovascular, pulmonary and thoracic, abdominal and urogenital injuries were severe.[3]

Anatomical site of impact, firing distance, and timely access to medical care were correlated with injury severity and risk of disability. Morbidity and mortality from KIPs often occurs as a result of shots to vital organs at close range including the head, neck, chest and abdomen.[3] Although the data are limited, rubber-coated metal bullets and those with composites of metal and plastic appear to be more lethal than plastic or rubber alone.[3] Though there is some evidence that "newer 'attenuated energy projectiles' (with a hollow plastic tip that collapses on impact or a soft sponged tip) may mitigate some injuries from ricochet or deep penetrative injury."[3]

Several studies have examined ocular injuries caused by KIPs and have found that the use of KIPs increase the incidence of debilitating ocular trauma.[12] For example, a study investigating cases of ocular trauma from KIPs during the civil unrest in Chile between October 18 and November 30, 2019 identified. KIPs as the suspected cause in 182 cases (70.5 percent).[13] Thirty-three cases had total blindness and 90 cases (49.5 percent) had severe visual impairment or were blind at first examination. Around 20 percent of the cases caused by KIPs had open-globe trauma.[13] Compared to other causes of ocular trauma, KIPs were related to a more severe loss of visual acuity and a higher frequency of open-globe injuries.[13]

Effects of Chemical Irritant Exposure

Chemical irritants such as tear gas and pepper spray are banned from use in warfare under the United Nations Chemical Weapons Convention (CWC). However, the CWC and local regulations stipulate that certain chemical agents may be used for riot control when officers give people adequate warning before releasing the agents and people have a reasonable route to escape any gas.[14] Chemical irritants used in crowd control have historically been considered by law enforcement to be safe and to cause only transient pain and lacrimation. However, in a recent publication, the National Institute of Justice notes that the deployment of pepper spray should be constrained and discusses the negative effects of pepper spray use.[15] Attempts have been made to catalogue the chemical irritants used by law enforcement but have been unsuccessful because of the number and variability of agencies and policies.[16]

Mixed reports exist regarding the effects of chemical irritants on people who are exposed. Some reports note that without medical attention, the effects of pepper spray and tear gas wane within several minutes; that significant adverse clinical effects, life-threatening conditions, and long-term effects are rare; and that death caused by chemical irritant exposure is unlikely.[15,17,18] However, numerous newer reports indicate that the use of these chemicals may cause serious injuries, have a significant potential for misuse, and cause unnecessary morbidity and mortality.[19–21] A systematic review found that among 9,261 injuries from chemical irritants, 8.7 percent were severe, two were lethal, and 58 caused permanent disabilities.[22–24] Studies have identified chronic bronchitis, compromised lung function, and acute lung injury as consequences of chemical irritant exposure.[22–24]

The International Association of Chiefs of Police (IACP)

The IACP, the world's largest professional association for police leaders with more than 31,000 members in over 165 countries, has established guidelines for managing crowds, protecting individual rights, and preserving the peace during demonstrations and civil disturbances. It is the policy of the IACP to "protect individual rights related to assembly and free speech; effectively manage crowds to prevent loss of life, injury, or property damage; and minimize disruption to persons who are not involved."[5]

ICAP's guidance provides that impact projectiles shall not be fired indiscriminately into crowds.[5] Non-direct (skip-fired) projectiles and munitions may be used in civil disturbances where life is in immediate jeopardy or the need to use the devices outweighs the potential risks involved.[5] Direct-fired KIPs may be used during civil disturbances against individuals engaged in conduct that poses an immediate threat of death or serious injury.[5] A verbal warning should be given prior to the use of KIPs when reasonably possible.

IACP provides that aerosol restraint spray, or oleoresin capsicum (OC), may be used against individuals engaged in unlawful conduct or actively resisting arrest, or as necessary in a defensive

capacity when appropriate.[5] OC spray shall not be used indiscriminately against groups of people where bystanders would be affected, or against passively resistant individuals.[5] High-volume OC delivery systems may be used in civil disturbances against groups of people engaged in unlawful acts or endangering public safety and security when approved by the incident commander.[5] Whenever reasonably possible, a verbal warning should be issued prior to the use of these systems.

CS (2-chlorobenzalmalononitrile) chemical agents are primarily offensive weapons to be used with the utmost caution. ICAP notes that CS may be deployed defensively to prevent injury when lesser force options are not available or would be ineffective.[5] These chemical agents are to deployed at the direction of the incident commander only when avenues of egress are available to the crowd. When reasonably possible, their use shall be announced to the crowd in advance. ICAP notes that CN (phenacyl chloride) shall not be used in any instance.[5]

The IACP has indicated that they plan to review their recommended policies on pepper spray and LLWs, including KIPs, as well as other aspects of crowd control. However, while the IACP makes recommendations, law enforcement agencies set their own policies.

United Nations

In 2019, the United Nations issued guidance on *Less Lethal Weapons in Law Enforcement*.[25] The guidance notes that law enforcement officials may only use force when strictly necessary and to the extent required for the performance of their duty. However, its acknowledged that law enforcement officials have the immense responsibility of determining, often in a matter of seconds and under hazardous conditions, whether force is necessary and, if so, how much is proportional to the threat they face with the possible cost of error being the loss of life.[25]

The guidance stresses the need for countries to supply law enforcement officials with effective, less-lethal means, and to train them in their lawful use.[25] The deployment of LLWs needs to be carefully evaluated to minimize the risk of endangering uninvolved persons and their use should be carefully controlled. The guidance recognizes that improper use of LLWs can cause serious injury or death.[25] Even LLWs "must be employed only when they are subject to strict requirements of necessity and proportionality, in situations in which other less harmful measures have proven to be or are clearly ineffective to address the threat."[25]

The guidance also makes it clear that LLWs have an important role in law enforcement. They may be used either in situations where some degree of force is necessary but where the use of firearms would be unlawful, or as a less dangerous alternative to firearms, to reduce the risk of injury to the public.[25] Where law enforcement officials are only equipped with a baton and a firearm, the risks to themselves and to the public may be heightened.[25]

State Legislation

At least seven cities and a few states have enacted or proposed limits on the use of KIPs and chemical irritants, though some efforts have stalled across the United States in the face of opposition from police agencies and other critics.[26,27]

The District of Columbia City Council enacted legislation, which provides that chemical irritants and less-lethal projectiles shall not be used to disperse a First Amendment assembly.[28] Legislation enacted in Colorado provides that in response to a protest or demonstration, a law enforcement agency shall not discharge KIPs and all other non- or less-lethal projectiles in a manner that targets the head, pelvis, or back; discharge kinetic impact projectiles indiscriminately into a crowd; or use

chemical agents or irritants, including pepper spray and tear gas, prior to issuing an order to disperse in a sufficient manner to ensure the order is heard and repeated if necessary, followed by sufficient time and space to allow compliance with the order.[29] In Massachusetts, a 2020 law provides that a law enforcement officer shall not discharge or order the discharge of tear gas or any other chemical weapon, or rubber pellets from a propulsion device or release to control or influence a person's behavior unless de-escalation tactics have been attempted and failed or are not feasible and the measures used are necessary to prevent imminent harm and the foreseeable harm inflected by the tear gas or other chemical weapon, rubber pellets is proportionate to the threat of imminent harm.[30] Oregon enacted legislation providing that a law enforcement agency may not use tear gas for the purpose of crowd control except in circumstances constituting a riot. Furthermore, before using tear gas in a riot, law enforcement shall: announce the agency's intent to use tear gas; allow sufficient time for individuals to evacuate the area; and announce for a second time, immediately before using the tear gas, the agency's intent to use tear gas.[31] Virginia enacted a bill prohibiting the use of KIPs unless necessary to protect a law enforcement officer or another person from bodily injury. The bill directs the Department of Criminal Justice Services to establish training standards for law enforcement on the use of KIPs and tear gas.

Federation of Medicine Statements and Positions

In June 2020, the American Thoracic Society called for "a moratorium on the use of tear gas and other chemical agents deployed by law enforcement against protestor participating in demonstrations, including current campaigns sparked by the death of George Floyd."[32] Citing significant short- and long-term respiratory health injury and likeliness of propagating the spread of viral illnesses including COVID-19, the potential to endanger innocent bystanders and the media, and concerns to medical personnel when treating protestors since the agents can contaminate clothing and medical equipment[32]. ATS also cited inadequate training, monitoring, and accountability in use of these weapons contribute to misuse and risk of injury. If used at all, tear gas should be a last resort.[32]

Also in June 2020, the American Academy of Ophthalmology (AAO) called on "domestic law enforcement officials to immediately end the use of rubber bullets to control or disperse crowds of protestors."[33] The statement noted that Americans have the right to speak and congregate publicly and should be able to exercise that right without the fear of blindness; people should not have to choose between their vision and their voice.[33] The following Federation members signed on to the AAO statement: American Academy of Allergy, Asthma and Immunology; American Academy of Family Physicians; American College of Surgeons; American Geriatrics Society; American Society of Nephrology; Council of Medical Specialty Societies; and the Society of Interventional Radiology.

CONCLUSION

The right of assembly plays a fundamental role in public participation in democracy, holding governments accountable, expressing the will of the people, and in amplifying the voices of people who are marginalized. For years, activists and civil libertarians worldwide have urged police to ban LLWs from use for crowd control.[34] Physicians and other health care personnel have witnessed first-hand the morbidity and mortality of LLWs. There have been calls for the development of national standards and training programs for years, but there has been little progress. At this time, based on the morbidity and mortality data available, the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management should be prohibited in the United States.

Law enforcement agencies oppose some restrictions on LLWs, saying the weapons are a critical tool to control uncooperative people that stops short of deadly force. Limiting access to LLWs could increase morbidity and mortality, requiring law enforcement officials to choose a more deadly form of force. There is some data available to suggest that the use of LLWs decreases the likelihood of suspect injury, which is why a complete ban of all KIPs and chemical irritants is not recommended at this time.[9,10] However, the AMA strongly encourages prioritizing the development and testing of crowd-control techniques which pose a more limited risk of physical harm.

While it is important to recognize that there may be a role for the use of LLWs by law enforcement, standards for their use should be clear. KIPs and chemical irritants can result in injury, disability and death, and they should not be used against crowds that pose no immediate threat. If KIPs and chemical irritants are going to be used, law enforcement agencies should have specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries. Appropriate de-escalation techniques should be used to minimize the risk of violence when feasible. Where force is necessary to achieve a legitimate law enforcement objective, precautionary steps should be taken to minimize, the risk of injury or death. Considerations should include the proximity of non-violent individuals and bystanders; for KIPs safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all LLWs, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 409, November 2020 Special Meeting, and the remainder of this report be filed.

Less-Lethal Weapons and Crowd Control

Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control peaceful crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-JUN-21

Subject:	Removing the Sex Designation from the Public Portion of the Birth Certificate (Resolution 5-I-19)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee D

Resolution 5-I-19, introduced by the Medical Student Section and referred by the House of Delegates asked that:

> Our American Medical Association advocate for the removal of sex as a legal designation on the public portion of the birth certificate and that it be visible for medical and statistical use only.

BACKGROUND

In the United States (U.S.), state laws require birth certificates to be completed for all births. Federal law mandates collection and publication of births and other vital statistics data, which occurs through cooperation between the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) and the states.[1] The National Vital Statistics System (NVSS) is the basis for the Nation's official statistics on births, deaths, marriages, and divorces.[2]

U.S. Standard Certificates of Live Birth

The U.S. Standard Certificates of Live Birth form is the primary means by which uniformity of data collection and processing is achieved, though each jurisdiction may adapt the standards to local needs.[3] The standard form is two pages in length and consists of 58 questions.[4] The questions include information on the child, and its mother or father. The child's sex is a question on the standard form. Typically, the form is completed by the parent(s) of the child, then certified by a medical professional, and submitted to the state, county, or municipality, which issues the final birth certificate back to the patent(s).

Data collected by state and territorial vital record entities are shared with the federal government under the Vital Statistics Cooperative Program (VSCP), which provides funding to jurisdictions to provide the standardized data to NCHS. These data are some of the most fundamental sources of health information, as they help in monitoring prevalence of disease, life expectancy, teenage pregnancy, and infant mortality, and in evaluating the effectiveness of public health interventions.[5]

Birth Certificates

The birth certificate is an official government-issued record of a person's birth, printed on security paper and including an official raised, embossed, impressed or multicolored seal.[6] The birth certificate is different from the Standard Certificate of Live Birth form as there is much less detail contained on the birth certificate. Generally, a birth certificate document will show a person's

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name, birthdate, place of birth, sex, parents' names, parents' age, and parents' place of birth. However, the information included on the birth certificate varies by state. Birth certificates are not public documents since they contain personal information. However, individuals are required to use their birth certificates for several reasons, including to obtain passports or driver's licenses, as well as registering for school, adoptions, employment, marriage or to access personal records.[7]

Sex Designation and Vital Records

Sex designation refers to the biological difference between males and females, which is what is recorded on the birth certificate. While there is no clear standard for defining sex designation, it is typically determined at birth by a child's physician or parents based on external genitalia. In cases where the anatomy is ambiguous or there are differences of sex development, diagnostic tests may be conducted and the parents and the medical team work together to assign sex at birth.

Gender is a social construct that describes the way persons self-identify or express themselves. A person's gender identity may not always be exclusively male or female and may not always correspond with their sex assigned at birth. Birth certificates have changed over time. In 1977, the Model State Vital Statistics Act for the first time addressed amending an individual's sex designation:

> Upon receipt of a certified copy of an order of (a court of competent jurisdiction) indicating the sex of an individual born in this State has been changed by surgical procedure and that such individuals name has been changed, the certificate of birth of such individual shall be amended as prescribed in Regulation 10.8 (e) to reflect such changes.[8]

Today, the majority of states (48) and the District of Columbia allow people to amend their sex designation on their birth certificate to reflect their individual identities, though this process varies by state.[9] Two states, Tennessee and Ohio, do not allow amendments of the sex marker on a birth certificate.[10] Thirty-one states and DC have an administrative process and 17 states require a court order.[11] Levels of medical evidence required to make these amendments also vary by jurisdiction, ranging from not requiring the signature of a medical provider to requiring proof of surgery.[12] Ten states currently allow for a gender-neutral designation on the birth certificate, typically an "X."[13]

EXISTING AMA POLICY

AMA Policy H-65.967, "Conforming Sex and Gender Designation on Government IDs and Other Documents," states that "the AMA supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification." The AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional. The AMA also supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, in addition to male and female. Furthermore, the AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs. Existing AMA policy does not address the removal of sex as a legal designation on the public portion of the birth certificate.

DISCUSSION

Vital events reporting is mandatory and is completed for nearly all births because birth certificates constitute proof of birth and citizenship. Birth certificates are used by the Social Security Administration to generate Social Security numbers, by the U.S. Department of State as evidence for passports, and by state departments of motor vehicles to issue driver's licenses.[14] They are essential to participate in essential activities such as school and employment. Historically, birth certificates have also been used to discriminate, promote racial hierarchies, and prohibit miscegenation.[15] For that reason, the race of an individual's parents is no longer listed on the public portion of birth certificates. However, sex designation is still included on the public portion of the birth certificate, despite the potential for discrimination.

Considerations for Transgender, Intersex, and Nonbinary Communities

Designating sex on birth certificates as male or female suggests that sex is simple and binary.[16] However, about 1 in 5,000 people have intersex variations; 6 in 1,000 people identify as transgender; and others are nonbinary (meaning they do not identify exclusively as a man or a woman) or gender nonconforming (meaning their behavior or appearance does not conform to prevailing cultural and social expectations about what is appropriate to their gender).[17] For these individuals, having a gender identity that does not match the sex designation on their birth certificate can result in confusion, possible discrimination, harassment and violence whenever their birth certificate is requested. Furthermore, public display of sex designation on the birth certificate requires disclosure of an individual's private, sensitive personal information.

Birth certificates are also viewed as important documents to prove one's identity. For the transgender community, the ability to change one's sex designation on birth certificates remains an important issue and is one for which there has been a significant legislative and judicial advocacy to change laws across the country.[18] If sex designation is removed from the public portion of the birth certificate, there are concerns that transgender individuals may not have government documentation confirming their gender identity. However, in most states, a person can change the gender marker on their driver's license, though the process varies by jurisdiction.[19] A passport can also serve this purpose. U.S. State Department policy provides that individual can obtain a passport reflecting their current gender by submitting certification from a physician confirming that they have had appropriate clinical treatment for gender transition, though no specific medical treatment is required.[20]

Ten states currently allow for a gender-neutral or "X" designation on birth certificates, which stands for "undisclosed" or "other." Some individuals may not want a gender-neutral designation on their or their child's birth certificate due to concerns about stigma. However, for others, the display of a more accurate gender marker provides validation. Gender-neutral birth certificates also allow people of any gender increased privacy around gender on their identification.[21] While some states have moved toward nonbinary or gender-neutral birth certificates, these options are not widely available across all government documents. Nineteen states and the District of Columbia currently allow a gender-neutral designation on driver's licenses.[22] The U.S. Department of State does not currently offer an option for a gender-neutral designation on U.S. passports.[23]

National Association for Public Health Statistics and Information Systems

The AMA contacted the National Association for Public Health Statistics and Information Systems (NAPHSIS), the nonprofit organization representing the state vital records and public health statistics offices in the United States, to confirm its position on removal of sex from the public

portion of the birth certificate. NAPHSIS indicated that it does not have an official position on this issue as an association but acknowledged that vitals were never intended to collect information on gender identity, only sex at birth.

AMA LGBTQ Advisory Committee Opinion

It is the recommendation of the AMA's LGBTQ Advisory Committee that our AMA should advocate for removal of sex as a legal designation on the public portion of birth certificates. Assigning sex using a binary variable and placing it on the public portion of the birth certificate perpetuates a view that it is immutable and fails to recognize the medical spectrum of gender identity. Participation by the medical profession and the government in assigning sex is often used as evidence supporting this binary view. Imposing such a categorization system risks stifling self-expression and self-identification and contributes to marginalization and minoritization. The Advisory Committee recognizes that moving sex designations below the line of demarcation will not address all aspects of the inequities transgender and intersex people face, but such an effort would represent a valuable first step, with the authoritative voice of our AMA leading the way.

CONCLUSION

Vital statistics data is a fundamental source of health information. In the U.S., the Standard Certificates of Live Birth form is the primary means by which uniformity of data collection and processing is achieved. Birth certificates, on the other hand, are issued by the government to individuals as proof of birth. Sex designation, as collected through the standard form and included on the birth certificate, refers to the biological difference between males and females. Today, the majority of states (48) and the District of Columbia allow people to amend their sex designation on their birth certificate to reflect their individual gender identities, but only 10 states allow for a gender-neutral designation, typically "X," on the birth certificate. Existing AMA policy recognizes that every individual has the right to determine their gender identity and sex designation on government documents. To protect individual privacy and to prevent discrimination, U.S. jurisdictions should remove sex designation on the birth certificate. While validation of gender has been raised as a concern with this approach, other government documents could serve this purpose in many jurisdictions. Furthermore, removal of sex designation from the birth certificate would have little to no impact on vital statistics data collected for medical, public health, and statistical purposes.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-19 and the remainder of this report be filed.

Our American Medical Association will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only. (Directive to Take Action).

Fiscal Note: Minimal – less than $500

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REPORT 16 OF THE BOARD OF TRUSTEES (June 2021)
Follow-up on Abnormal Medical Test Findings
(Resolution 309-I-19)
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. Resolution 309-I-19, "Follow-up on Abnormal Medical Test Findings," asked that our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes and work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. However, there is currently no standardized definition for 'abnormal medical test findings.' Terminology can vary markedly around the degree of abnormality, required timeliness of the communication, and associated patient outcomes. Related definitions include "urgent, critical, acute, alert, emergent, abnormal, markedly or significantly abnormal, [and] clinically significant.

DISCUSSION. Notification preferences can evolve over time and include tradeoffs in terms of ease of use and degree of security. The ideal communication method may include an office visit, phone call, text, postal mail, email and/or the use of an online patient portal. Preferences may vary between patients and between different types of test results. Guidelines around notification should be flexible so that they can be tailored to meet various practice and patient needs. Overall, flexibility in approach to reporting abnormal and critical results is likely to continue to remain desirable. Flexibility is also needed to support communication policies that are standard practice in medicine such as brief embargo periods to enable care coordination, closing the referral loop, consultation, discussion of complex findings, care team planning, and/or other medically appropriate purposes. Such flexibility may be more readily accomplished by tailored clinical practice guidelines and local programs rather than broad mandates via additional regulation. Guidelines offered by medical specialty societies have the potential to help optimize appropriate notification frequency and response. Additional research is needed to develop best practices for communication of test results including via patient portals and apps.

CONCLUSION. While the AMA has extensive policy on medical test reporting and certainly agrees that reporting test results in a timely manner is an important patient safety issue, it is the role of national medical specialty societies to develop evidence-based guidelines on communicating with patients regarding abnormal test results. Communication requirements may vary by facility or jurisdiction and communication preferences may vary between patients and between different types of test results. As outlined in this report, there are existing tools and resources that physicians can leverage to facilitate communication with patients on abnormal and critical test findings. The report recommends that the AMA highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings and support the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-JUN-21

Subject: Follow-up on Abnormal Medical Test Findings (Resolution 309-I-19)

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 309-I-19, "Follow-up on Abnormal Medical Test Findings," which was introduced by the Georgia Delegation and referred by the House of Delegates, asked that:

> Our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes; and
>
> Our AMA work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes.

CURRENT AMA POLICY

Existing AMA policy addresses medical test results and follow-up (see Appendix for full text). AMA Policy D-260.995, "Improvements to Reporting of Clinical Laboratory Results," encourages the usability and standardization of clinical laboratory reports including clearly identifiable diagnoses and test results. AMA Policy H-155.994, "Sharing of Diagnostic Findings," encourages providers to develop mechanisms for the sharing of diagnostic findings to avoid duplication of expensive diagnostic tests and procedures. AMA Policies H-478.979, "Quality Payment Program and the Immediate Availability of Results in Certified Electronic Health Record Technologies," and D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health Records," address best practices for patient portals including education and sharing of medical test results. AMA Policy H-425.968, "Non-Physician Screening Tests," advocates for requiring consultation with a patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result.

BACKGROUND

Medical testing is essential for providing quality health care. Testing services are frequently divided between the branches of laboratory medicine, anatomic pathology, and medical imaging. Other medical specialties also perform many additional forms of testing including mental health assessments, hearing and vision tests, sleep apnea tests, and neurocognitive tests. Test results are used for diagnostic and other medical decision-making purposes, with interpretation taking into account additional patient context.[1]

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With approximately 14 billion clinical laboratory tests performed annually in the U.S.,[2] laboratory medicine is tightly integrated into nearly every physician's daily practice. Laboratory tests, and other test results including anatomic pathology and medical imaging, support clinical decision-making to assist the management of most human disorders. Tests also play an indispensable supportive role for models of evidence-based medicine and precision medicine.

Defining abnormal and critical test results

There is currently no standardized definition for 'abnormal medical test findings.' Terminology can vary markedly around the degree of abnormality, required timeliness of the communication, and associated patient outcomes. Related definitions include "urgent, critical, acute, alert, emergent, abnormal, markedly or significantly abnormal, [and] clinically significant."[3] An abnormal result is often understood in the context of a reference range, e.g., a value in the 95th percentile. However, reference ranges derived from population studies may not account for how patient characteristics such as age, sex, ethnicity, or specific conditions affect the likelihood of results being flagged as out-of-range. Reference ranges based on race are currently being reevaluated given concerns that race is a social and not biological construct. Given natural variation between individuals and testing variability, in many cases such results may not require changes in patient management or may be considered false positives.

Interpretation of test results is also highly dependent on the overall clinical context, including working diagnosis, signs and symptoms, and a specific clinical question to be answered.[4] For example, when evaluating patients for adherence to prescribed opioids, levels of circulating opioid below a certain threshold or a negative result may be flagged as abnormal. On the other hand, when screening patients who have not been prescribed opioids, any positive result may instead be flagged as abnormal.[5] Accordingly, availability of other information about the patient can greatly enhance the clinical relevance of the test report and may be essential for optimal interpretation of results and patient care, including determining what findings may be considered abnormal for an individual patient.

On the other hand, some test results require timely clinical evaluation because they are associated with life-threatening conditions (or imminent clinical deterioration), for which a clinical action is possible. Lundberg initially defined critical or "panic" values as "values which reflect pathophysiological derangements at such variance with normal as to be life threatening if therapy is not instituted immediately." His team also pioneered a system for communicating urgent results, including recognition, verification and finding a clinician who can take appropriate action.[6–8]

The Joint Commission (TJC) has established a set of definitions that can inform institutional policy around reporting results. These include "critical test results" defined as "any result or finding that may be considered life threatening or that could result in severe morbidity and require urgent or emergent clinical attention." In contrast, "critical tests" have been defined as "tests that require rapid communication of results, whether normal, abnormal, or critical." Furthermore, "significant risk results" have been defined as "nonemergent, non-life-threatening results that need attention and follow-up action as soon as possible, but for which timing is not as crucial as critical results. They generate a mandatory notification in the electronic health record but are not required to be reported verbally."[9–11] Inclusion of these definitions within an institutional policy can help guide communication of test results, although the measures that are "critical" or "significant" must still be defined at the institutional level. Once defined, the requirement would then be to follow these locally adopted procedures including reporting timeframes.

Setting Thresholds for Critical Values

Health systems may develop their own written procedures to manage critical results, including definitions, to whom results should be reported, and acceptable timing for reporting.[11] By design, each laboratory and health system may be responsible for setting its own critical values which may trigger different responses at different levels.[7] Some health systems seek alignment with critical values from reference laboratories to promote consistency in reporting, but physicians may also customize critical values for select tests and patient groups.[12]

There is a scarcity of outcomes-based data that examine optimal alert thresholds across diverse patient populations to help determine when clinical action should be taken.[8,13] In addition, variation in measurement between laboratories may also require that each laboratory director define critical ranges according to the assays and instrumentation currently in use. Currently, critical value thresholds are largely determined by consensus and expert opinions.[14] Movement towards evidence-based clinical decision limits (that empirically determine values for which a clinical action is most appropriate) will likely require long-term efforts to collect sufficient evidence, including from randomized controlled trials.

DISCUSSION

National Academies of Science, Engineering and Medicine

A lack of timely reporting of test results may have adverse impacts including patient harm when there is delay in access to appropriate treatment. The National Academies of Science, Engineering and Medicine (NASEM) released the report "Improving Diagnosis in Health Care" in 2015. This work highlights how patient safety and health care quality can be improved through a systems approach that centers on the diagnostic process. The report takes the patient's viewpoint to define diagnostic error as "the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient." The report's recommendations include facilitating more effective teamwork among health care professionals, partnering with patients to include increased engagement around the diagnostic process, and ensuring effective and timely communication of results. The scope of diagnostic errors in medicine has remained difficult to measure, though there is some evidence that most patients may be affected at least once during their lifetime.[1]

Clinical and Laboratory Standards Institute Guidelines

Some effort has been made to standardize and harmonize critical results management both nationally and internationally taking into account the wide range of differences between laboratories.[13] For example, the Clinical and Laboratory Standards Institute (CLSI) has provided guidelines for laboratory directors and administrators for local policy development around "Management of Critical- and Significant-Risk Results."[15] Nevertheless, there is often an explicit acknowledgement that "there should be some degree of flexibility for modification by each individual laboratory."[16] There also remains a lack of consensus around policies for implementing critical laboratory values among national and international organizations.[9]

Medical Specialty Society Guidelines

Guidelines are available to support reporting results from some types of imaging studies and tests. For example, the American College of Radiology (ACR) offers appropriateness criteria for communication of diagnostic imaging. These recommendations cover the importance of timely

reporting, the need for an interpreting physician to have access to previous tests and reports, when there may be a responsibility to communicate results directly to a patient, the method of non-routine communication between a laboratory and ordering physician (typically by phone or in person), patient access to results, and how to handle report discrepancies.[4] The ACR also provides more detailed guidance for reporting specific tests including mammography. This includes reporting systems with specific assessment categories such as BI-RADS® that are tied to management recommendations and risk level.[17]

In addition, international guidelines and consensus statements around communication of test results include those from the Royal College of Pathologists (RCP). The RCP recommends that laboratories should compile alert lists including high risk results, specify the mode of transmission and to whom results should be reported, develop systems to acknowledge and document receipt of test results, and have procedures to monitor outcomes.[18] There is an acknowledged need for additional consensus around definitions as well as outcomes-based evidence to identify alert thresholds where clinical action can help mitigate risk while minimizing false positives.[13]

Regulation of Testing and Results Reporting

Federal and state laws regulate laboratory testing, anatomic pathology, and imaging services. Clinical Laboratory Improvement Amendments (CLIA) of 1988 address laboratory testing performed on humans in the U.S. These laboratory standards include specifications for quality control, quality assurance, patient test management, and proficiency testing. There are now over 200,000 CLIA-certified laboratories.[19]

Regulatory bodies may also require critical results reporting on a timely basis. For example, under CLIA regulations, "The laboratory must immediately alert the individual or entity requesting the test and, if applicable, the individual responsible for using the test results when any test result indicates an imminently life-threatening condition, or panic or alert values."[20,21] There is a requirement for the laboratory to have written policies and procedures around critical value reporting. Individual laboratories create their own lists for which analytes are to be included in the definition of a critical value, as well as the high and low values. Regulatory agencies do not include which tests and limits are included but instead leave these decisions to laboratory directors, including how contact and documentation of communication should be made.

Direct reporting of any significant abnormalities within imaging results was mandated under a recent state law. The "Patient Test Result Information Act" (Pennsylvania Act 112 of 2018) took effect in December of 2019. This law defined "significant abnormalities" as those that that "would cause a reasonably prudent person to seek additional or follow-up medical care within three months." The law requires reporting of results to the patient as well as to the ordering physician.[22,23] Data are needed to assess the impact of this type of requirement on patient outcomes.

Accreditation of Testing and Results Reporting

Critical results reporting has been identified as a National Patient Safety Goal by the College of American Pathologists (CAP). These goals include establishing laboratory procedures outlining "by whom and to whom" to report any critical results, as well as defining an acceptable delay between availability and the reporting of critical results. Notification burden including placing phone calls is likely to continue to shift away from laboratory personnel, in part due a shortage in laboratory professionals, towards automated notification systems.[8] TJC has a similar National Patient Safety Goal to provide "the responsible, licensed caregiver" a report of all critical results within the defined timeframe that was established by the laboratory.

The Mammography Quality Standards Act (MQSA) of 1992 requires mammography facilities across the nation to meet uniform quality standards where each facility must be accredited and certified. The FDA recognizes the ACR as a nationally approved accreditation body. At the state level, accreditation may also be provided by the Iowa Department of Public Health, Arkansas Department of Health, and Texas Department of State Health Services. Certification bodies for MQSA include the FDA, Iowa, Illinois and South Carolina.[24] MQSA addresses report generation and communication of screening findings. It also facilitates data collection for monitoring and improvement.

Regulation of Interoperability and Information Blocking

The 21st Century Cures Act of 2016 includes interoperability and "information blocking" provisions that mandate sharing of electronic health information. An ongoing concern has been that physicians may be required to release office notes and test results prior to physician review of the information with the patient. It is important to also note that once a patient opts to share electronic health records and other health data, for example with third-party vendors or smartphone applications (apps), the information may no longer be protected under certain federal or state privacy laws, e.g., the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Third-party access, including by payers and apps, may include a patient's genetic test results and other sensitive information such as behavioral health, potentially compounding data privacy and security concerns. Payers are covered entities under HIPAA and the law includes provisions around the use of patient information for treatment, payment, and health care operations. However, HIPAA protections generally cover where data resides and not the data itself. For instance, covered entity to covered entity data exchange is regulated (e.g., physicians sending medical information to payers). Payers who receive or access information from entities not covered by HIPAA (e.g., app developers) can use the information to create discriminatory profiling—affecting patients' access to care and coverage.

The AMA has advocated for additional clarity around these new regulations, in part due to their complexity, and has also requested an extension to prioritize COVID-19 response. The current compliance deadline or "applicability date" is April 5, 2021. The AMA has also developed educational resources[25] and continues to work with the federal government on implementation of these new regulations to reduce burden for physician compliance and to address privacy concerns and other impacts to patients.

Programs, Policies, and Tools

Policies defined at the local level can help address various aspects of reporting including the acceptable length of time between test completion and reporting critical test results, as well as outlining a procedure for how to effectively communicate the results. The Compass Hospital Improvement Innovation Network surveyed "best in class" performers for their "change package" called *Reducing Diagnostic Error Related to the Laboratory Testing Process*. This includes a focus on standardizing protocols for test reports and communicating patient test results, developing a communications plan to help close the loop, and reporting at a regular frequency.[26]

The Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Hospital Association collaborated to develop practice recommendations emphasizing timely communication of critical test results. Their safe practice recommendations include addressing who should receive the results, the notification process, and what results require explicit time frames.[27] The American College of Obstetricians and Gynecologists released a committee opinion on tracking and reminder

systems to facilitate patient communication. This opinion outlines the design and implementation of a tracking and reminder system to help handle notification of test results.[28]

The Office of the National Coordinator for Health Information Technology (ONC) offers Safety Assurance Factors for EHR Resilience (SAFER) Self-Assessment Guides to address safety concerns faced by health care organizations.[29] The SAFER guide on Test Results Reporting and Follow-Up includes a checklist and recommended practice worksheets with rationale and examples for how to implement. The self-assessment facilitates engagement of clinician leadership to reach consensus on priorities, resources and methods of ensuring that recommended practices for communication and management of diagnostic test result are in place.

The ECRI Institute's Partnership for Health IT Patient Safety offers a toolkit called "Closing the Loop: Using Health IT to Mitigate Delayed, Missed, and Incorrect Diagnoses Related to Diagnostic Testing and Medication Changes."[30] Their recommendations include "to develop and apply IT solutions to communicate the right information (including data needed for interpretation), to the right people, at the right time, in the right format, using the right channel." This recommendation focuses on three domains: improving communication, tracking of loop closure, and linking acknowledgment to action taken.

The Agency for Healthcare Research and Quality (AHRQ) has released a "Toolkit for Rapid-Cycle Patient Safety and Quality Improvement."[31] This toolkit uses the "Plan-Do-Study-Act (PDSA) Method for Practice Improvement" to survey the entire staff to highlight potential quality and safety issues that can be addressed to improve the reliability of the office testing process. The toolkit includes a patient engagement survey and handout to assess patient experiences. This approach can help offices to determine how often patients with abnormal results are not being monitored through follow-up and what the consequences may be. The tool also facilitates auditing medical records to examine whether patients were notified of results within the timeframe specified by the office policy and to plan for improvements and measure progress.

Potential Impacts for Physicians and Patients

Notification preferences can evolve over time and include tradeoffs in terms of ease of use and degree of security.[32,33] The ideal communication method may include an office visit, phone call, text, postal mail, email and/or the use of an online patient portal. Preferences may vary between patients and between different types of test results. Guidelines around notification should be flexible so that they can be tailored to meet various practice and patient needs.

Overall, flexibility in approach to reporting abnormal and critical results is likely to continue to remain desirable. Flexibility is also needed to support communication policies that are standard practice in medicine such as brief embargo periods to enable care coordination, closing the referral loop, consultation, discussion of complex findings, care team planning, and/or other medically appropriate purposes. Such flexibility may be more readily accomplished by tailored clinical practice guidelines and local programs rather than broad mandates via additional regulation. For example, MQSA has been associated with decreasing variability in mammography since enacted in 1992, but in general such regulatory approaches may be considered complex and inflexible and may increase administrative burden. MQSA also does not cover newer screening technologies.[1]

Online patient portals have the capacity to provide early access to test results in the absence of meaningful interpretation by a physician.[34] While patients should have timely access to their test results, providing such information without additional context or explanation at the appropriate

health literacy level may increase anxiety for some patients.[35] Patients may also encounter challenges accessing the results or require additional support.[36]

Finally, systems reporting test results should be designed in a manner that minimizes unnecessary notification burden and avoids information overload and alert fatigue for physicians.[37] Guidelines offered by medical specialty societies have the potential to help optimize appropriate notification frequency and response. Additional research is needed to develop best practices for communication of test results including via patient portals and apps.

CONCLUSION

This resolution asks the AMA to advocate for the adoption of evidence-based guidelines and enhance the availability of continuing education on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. While the AMA has extensive policy on medical test reporting and certainly agrees that reporting test results in a timely manner is an important patient safety issue, it is the role of national medical specialty societies to develop evidence-based guidelines on communicating with patients regarding abnormal test results. Communication requirements may vary by facility or jurisdiction and communication preferences may vary between patients and between different types of test results. As outlined in this report, there are a number of existing tools and resources that physicians can leverage to facilitate communication with patients on abnormal and critical test findings.

RECOMMENDATIONS

The Board of Trustees recommends that the language below be adopted in lieu of Resolution 309-I-19 and the remainder of this report be filed.

> Our American Medical Association encourages relevant national medical specialty societies to develop and disseminate evidence-based guidelines for communication and follow-up of abnormal and critical test results to promote better patient outcomes. (New HOD Policy)
>
> Our AMA will work with appropriate state and medical specialty societies to highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings to promote better patient outcomes. (Directive to Take Action)
>
> Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care. (New HOD Policy)

Fiscal Note: Less than $500

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APPENDIX – Current AMA Policy

D-260.995, "Improvements to Reporting of Clinical Laboratory Results"
1. Our AMA will: (a) make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority; and (b) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results. 2. Our AMA will encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety. 3. Our AMA will support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization.

H-155.994, "Sharing of Diagnostic Findings"
The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.

H-478.979, "Quality Payment Program and the Immediate Availability of Results in Certified Electronic Health Record Technologies"
Our AMA: (1) urges the Centers for Medicare & Medicaid Services, Office of the National Coordinator for Health Information Technology, and other agencies with jurisdiction to create guardrails around the "immediate" availability of medical test results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results; and (2) encourages vendors to implement mechanisms that provide physicians the discretion to publish medical test results to a patient portal while ensuring patient access to such information in a reasonable timeframe.

D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health Records"
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.

H-425.968, "Non-Physician Screening Tests"
1. AMA policy is that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles: a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines; b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed; c. Must disclose the qualifications of any persons in contact with

the patient and of any persons interpreting the results of any screening test; d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure; e. Should send results of any screening to the individual patient and to the primary care physician or usual source of medical care, upon patient request; f. Should require a consultation with the patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result; g. If the test results are of a critical level or value, the patient should be contacted immediately and notified of the need for urgent or emergent medical evaluation. 2. Our AMA supports that physicians not be held liable for delayed or missed diagnoses indicated on wellness program vendor non-physician ordered screenings.

Code of Medical Ethics 2.1.5, "Reporting Clinical Test Results"
Patients should be able to be confident that they will receive the results of clinical tests in a timely fashion. Physicians have a corresponding obligation to be considerate of patient concerns and anxieties and ensure that patients receive test results within a reasonable time frame. When and how clinical test results are conveyed to patients can vary considerably in different practice environments and for different clinical tests. In some instances results are conveyed by the patient's treating physician, in others by other practice staff, or directly by the laboratory or other entity. To ensure that test results are communicated appropriately to patients, physicians should adopt, or advocate for, policies and procedures to ensure that: (a) The patient (or surrogate decision maker if the patient lacks decision-making capacity) is informed about when he or she can reasonably expect to learn the results of clinical tests and how those results will be conveyed. (b) The patient/surrogate is instructed what to do if he or she does not receive results in the expected time frame. (c) Test results are conveyed sensitively, in a way that is understandable to the patient/surrogate, and the patient/surrogate receives information needed to make well-considered decisions about medical treatment and give informed consent to future treatment. (d) Patient confidentiality is protected regardless of how clinical test results are conveyed. (e) The ordering physician is notified before the disclosure takes place and has access to the results as they will be conveyed to the patient/surrogate, if results are to be conveyed directly to the patient/surrogate by a third party.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-JUN-21

Subject: Council on Science and Public Health Sunset Review of 2011 House Policies

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

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

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

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

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

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

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

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RECOMMENDATION

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

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-100.977	Pharmaceutical Quality Control for Foreign Medications	Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients. Citation: Res. 508, A-08;	Retain; still relevant
D-100.978	FDA Drug Safety Policies	Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. Citation: Sub. Res. 505, A-08;	Retain; still relevant.
D-115.989	Consumer Friendly Medication Identification	Our AMA: 1) strongly recommends to drug manufacturers worldwide that they put a consumer-friendly, unique identifier on the solid dosage form itself; and 2) recommends to the publishers of comprehensive lists of medications (such as PDR, Epocrates) that they include in their publications a list of these abbreviations. Citation: Res. 519, A-11;	Retain; still relevant.
D-120.952	Measuring Medication Dosages	Our AMA supports the development of guidelines to eliminate medication dosing inconsistencies. Citation: Res. 505, A-11;	Retain; remains relevant and in alignment with AMA's work as a founding member of the National Coordinating Council for Medication Error Prevention (NCCMERP).
D-120.984	Streamlining the Process for Prescription Refills	Our AMA will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety. Citation: (Sub Res. 522, A-03; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
D-135.979	Prevalence of Nickel Sensitization in the USA	Our AMA: 1) recognizes ~~encourages appropriate federal agencies to issue an advisory on~~ the ~~growing~~ prevalence of nickel sensitization, and need to ~~promote measures which~~ protect patients, consumers, and workers from the health risks of nickel sensitization; and 2) encourages the appropriate organization ~~Consumer Product Safety Commission~~ to issue guidelines ~~a directive~~ limiting maximum allowable release of nickel from products with prolonged skin contact.	Retain in part as amended; change to H-policy. The Nickel Institute has developed myriad resources about nickel, safe use, risks, and sensitization and the issue is well-

		Citation: (Res. 522, A-11)	documented in literature. However, no organization has issued guidelines for maximum allowable nickel release.
D-135.989	NAAQS Standard for Ozone	1. Our AMA ~~will sign on or endorse comments submitted by the ATS and American Lung Association~~ support~~sing~~ a tightening of the NAAQS for ozone to include an ozone NAAQS of 0.060 ppm for the 8-hour standard. ~~2. Our AMA will submit comments to President Obama expressing opposition to his decision to delay updating the EPA ozone standard and send a letter to President Obama noting that delayed setting and enforcement of a stricter ozone standard will result in more adverse health effects including asthma and COPD exacerbations, emergency room visits, hospitalizations and death.~~ Citation: (BOT Action in response to referred for decision Res. 416, A-07 and Res. 438, A-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation I-09; Appended: Res. 929, I-11)	Retain in part as amended; change to H-policy. On October 1, 2015, EPA strengthened the ground-level ozone standard to 0.070 ppm (from 0.075 ppm), averaged over an 8-hour period.
D-150.977	Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility	Our AMA: 1) will work with appropriate agencies, organizations, and corporations to educate health professionals and the public about healthy food choices in fast food restaurants; and 2) supports personal and parental responsibility to encourage healthy childhood behaviors, including the consumption of healthy food. Citation: (Sub. Res. 402, A-11)	Retain; still relevant.
D-20.988	HIV Education in Minority Populations	Our AMA will: 1) increase its efforts to educate minority populations regarding the risk of HIV infection across all age groups, socioeconomic class, and sexual orientation thereby preventing the spread of infection, increase early testing, and decrease the spread of this epidemic; and 2) partner with public and private organizations dedicated to public health education and preventive medicine to decrease the incidence of HIV infection and increase early intervention efforts. Citation: (Res. 405, A-11)	Retain; still relevant.
D-20.995	Universal, Routine Screening of Pregnant Women for HIV Infection	Our AMA will support the recommendations of the Institute of Medicine's report on perinatal HIV transmission, "Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States." Citation: (CSA Rep. 1, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. Addressed by Policy H-20.918, "Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission"
D-30.998	Prevention of Repeat Driving Under the Influence (DUI) Offenses: The	Our AMA encourages: (1) physicians and their state medical societies to work to create statutes that are designed to treat patients, protect the community and families, and grant immunity to physicians for good faith reporting of drug or	Retain; still relevant.

	Issues of Diversion and Treatment and Vehicle Incapacitation	alcohol impaired drivers for both permitted or mandated reporting; and (2) further research into and professional discussion about the issues of reporting medical information that could result in punishment or criminal prosecution. Citation: (BOT Rep. 17, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	
D-425.996	Implementing the Guidelines to Community Preventive Services	Our AMA will : (1) commend the Centers for Disease Control and Prevention (CDC) and the Task Force on Community Preventive Services for their work in developing the Guides to Community Preventive Services; (2) review the recommendations and conclusions of the Task Force on Community Preventive Services and recommend to the House of Delegates the appropriate actions as per AMA policy; ~~(3) express to the Director of CDC AMA's interest in having a liaison and alternate on the Task Force on Community Preventive Services; and~~ (43) promote the visibility of the recommendations of the Guides to Community Preventive Services as they become available, provided those recommendations comport with AMA policies and standards. Citation: (CSA Rep. 6, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part. The AMA is engaged with the Community Preventive Services Task Force and has a primary and alternate liaison.
D-440.956	Expanding the Vaccines for Children Program	Our AMA will work with its immunization partners to examine methods to improve financing mechanisms for vaccines, including the expansion of the Vaccine for Children program. Citation: (Res. 534, A-06; Reaffirmation A-07; Reaffirmation I-10; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11)	Retain; still relevant.
D-490.976	Tobacco Settlement Fund	Our AMA supports state and local medical societies in their efforts to formally request that local and state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state's Tobacco Settlement Fund award annually to smoking cessation and health care related programs, and encourages society members and the public to demand this of their elected officials. Citation: (Res. 431, A-07; Reaffirmation I-11)	Rescind. Covered by H-495.983, "Tobacco Litigation Settlements," which reads: Our AMA:(1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and

			for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco

			companies or tobacco products. Citation: (CSA Rep. 3, A-04; Reaffirmation I-11)
D-490.978	Tobacco Usage	Our AMA will: (1) advocate for the use of the tobacco settlement funds for informational public service campaigns related to smoking cessation, especially as related to young people; and (2) send a formal letter to the appropriate authority in each state and territory that was party to the tobacco settlement for an accounting of past and projected future expenditures related to smoking cessation, especially as related to young people. Citation: (Res. 408, A-06; Reaffirmation I-11)	Rescind. Covered by H-495.983, "Tobacco Litigation Settlements" (see above)
D-490.984	AMA Opposition to Securitization of Tobacco Settlement Payments	Our AMA will work in concert with state medical societies to protect the settlement funds, including issuing statements condemning the use of settlement funds as a way to remedy state budget crises. Citation: (BOT Rep. 3, I-03; Reaffirmation I-11)	Retain; still relevant.
D-490.997	Continued Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services	Our AMA will: (1) translate that commitment into action through aggressive lobbying activities to encourage and work with state and specialty societies to vigorously lobby state legislatures to: (a) assure that a significant percentage (depending on the objectively determined needs of the state) of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services; (b) assemble an appointed state level task force, when needed, that includes experts in public health, smoking cessation and tobacco prevention programs to ensure that funds are spent on activities supported by the Centers for Disease Control and Prevention guidelines. Citation: (Res. 428, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation I-11)	Rescind. Covered by H-495.983, "Tobacco Litigation Settlements" (see above)
D-60.994	Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles	Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse. Citation: (Res. 401, A-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
D-95.979	Banning Synthetic Drugs Referred to as "Bath Salts"	Our AMA supports national legislation banning synthetic drugs referred to as "bath salts," containing methylenedioxypyrovalerone (MDPV), mephedrone, and related substances. Citation: (Res. 507, A-11; Reaffirmation I-11)	Rescind. Remains relevant, but because bath salts are new psychoactive substances, the issue is addressed in Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use,"

			which reads: Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4)

			encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.
H-10.983	Swimming Safety	Our AMA (1) strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs and (2) encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety. Citation: (Res. 72, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-10.984	Farm-Related Injuries	Our AMA (1) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries; (2) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries. Physicians in rural areas should assume leadership roles in developing these facilities; (3) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement; (4) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of	Retain; still relevant.

		agricultural injuries and about approaches to their prevention; (5) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; and (6) encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. Citation: (BOT Rep. U, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-115.968	Decreasing Epinephrine Auto-Injector Accidents and Misuse	Our AMA: 1) encourages physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and 2) encourages improved product design and labeling of epinephrine auto-injectors. Citation: (Res. 513, A-11)	Retain; still relevant.
H-115.969	Consumer Medication Information	Our AMA supports the following basic principles for supplying written prescription drug information to patients: That (1) our AMA supports the pursuit of a single document for the provision of written consumer medication information (CMI), replacing the current framework of patient package inserts, pharmacy generated prescription drug leaflets, and Medication Guides; (2) the FDA collaboratively develop, test, and implement a single-document CMI process based on rigorously defined, essential information needed by patients to safely and effectively use medications; (3) the FDA validate CMI prototypes in actual use studies; (4) CMI should be provided in electronic formats on a publicly accessible Web site so that prescribers have access to these tools for improving patient adherence; and (5) CMI should stand on its own and not be an integral component of pharmacy marketing activities. Citation: (CSAPH Rep. 3, A-11)	Retain; still relevant.
H-115.979	Policy to Reduce Waste from Pharmaceutical Sample Packaging	Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy. Citation: (Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-115.984	Product Identification of Solid Dosage Forms	Our AMA supports working with the appropriate organizations to: (1) develop a coding system for the identification of all solid medication forms; (2) encourage imprinting each tablet, capsule or other solid dosage form of a prescription drug with its unique code and the name or other distinctive mark	Rescind. CFR Title 21, Volume 4 requires that “a code imprint that, in conjunction with the product's size, shape,

		identifying the manufacturer; and (3) encourage compilation of this coding system into a reference and disseminate it to physicians, pharmacists and law enforcement agencies in an appropriate manner. Citation: (Res. 44, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 519, A-11)	and color, permits the unique identification of the drug product and the manufacturer or distributor of the product." Many compilations of the coding system exist on the Internet, free to access.
H-120.940	Mail Order Pharmacies and Interface with Current Pharmacy Hubs	Our AMA will: (1) work with mail order pharmacies to make sure that such pharmacies adopt interfaces with current pharmacy hubs and physician electronic prescribing systems at no cost to physicians; and (2) advocate for penalties and/or incentives for mail order pharmacies to encourage the adoption of a functional system to automate the prescribing process through interfaces with physicians electronic prescribing systems. Citation: (Res. 708, A-10; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
H-120.967	Dispensing of ~~Computer-Generated~~ Drug Information	1. Our AMA continues to cooperate with ~~the National Council on Patient Information and Education (NCPIE),~~ USP, the FDA and others to establish standards for patient information. 2. ~~Our AMA continues to participate on the NCPIE to foster better medication use through improved communication between physicians and their patients, and the AMA encourages state and specialty medical societies to become members of NCPIE.~~ ~~3.~~ Our AMA will monitor the ongoing re-evaluation of how consumer medication information is designed and provided in the US and provide input to ensure that such documents are clinically useful, written at the appropriate literacy level, and promote patient adherence. Citation: (Res. 512, A-95; Appended: Sub. Res. 508, A-10; Reaffirmed: CSAPH Rep. 3, A-11)	Retain in part. AMA is no longer a member of NCPIE, as they merged with a new organization and are funded, in part, by pharmaceutical companies.
H-120.987	American Pharmacists Association	The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled. Citation: (Res. 147, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11)	Retain; still relevant.
H-120.989	Mail Service Pharmacy	The AMA believes that: (1) MSP is an established alternative method of distributing drugs in the	Retain; still relevant.

		United States. (2) Controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe. (3) Mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician. (4) Any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations. (5) Physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs. Citation: (BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11)	
H-130.956	Screening for Alcohol and Other Drug Use in Trauma Patients	Our AMA (1) encourages hospital medical staffs to promote the performance of blood alcohol concentration (BAC) tests and urine drug screens on hospitalized trauma patients; and (2) urges physicians responsible for the care of hospitalized trauma patients to implement appropriate evaluation and treatment when there is a positive BAC, other positive drug screen result, or other source of suspicion of ~~a~~ potential substance misuse or substance use disorder. Citation: (BOT Rep. J, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant
H-130.987	Emergency Medical Identification Aids	Our AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying	Retain; still relevant.

		family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; (4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card; and (5) recognizes the need for patients to have the option to enroll in portable medical identification alert systems that current technologies support, such as virtual medical identification alert systems and smart cards which can offer emergency responders immediate access to pertinent health information and family contact information. Citation: (BOT Rep. U, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed by CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 815, I-11)	
H-135.933	Bisphenol A	Our AMA: 1) supports a ~~shift to~~ a ~~more~~ robust, science-based, and transparent federal regulatory framework for oversight of bisphenol A (BPA); and 2) ~~encourages ongoing industry actions to stop producing BPA-containing baby bottles and infant feeding cups, support bans on the sale of such products, and urge the development and use of safe, nonharmful alternatives to BPA for the linings of infant formula cans and other food can linings; and 3)~~ recognizes BPA as an endocrine-disrupting agent and urges that BPA-containing products with the potential to increase human exposure to BPA be clearly identified. Citation: (CSAPH Rep. 5, A-11)	Retain in part. In July 2012, FDA amended its regulations to no longer provide for the use of BPA-based resins in baby bottles, sippy cups, and packaging coatings for infant formula because these specified uses have been permanently and completely abandoned.
H-135.947	Guidance for Worldwide Conservation of Potable Water	Our AMA favors scientific and cultural development of a plan for worldwide potable water conservation, especially in countries affected by natural disasters or other events that disrupt the potable water supply. Citation: (Res. 406, A-04; Modified in lieu of Res. 906, I-11)	Retain; still relevant.
H-135.950	Support the Health Based Provisions of the Clean Air Act	Our AMA ~~(1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3)~~ opposes ~~further~~ legislation to weaken the existing provisions of the Clean Air Act. Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11)	Retain in part. The New Source Review (NSR) program is complex, has a long history of rulemakings, guidance, applicability determinations and litigation that have NSR applicability. Given the many changes over the years, it is not clear what specifically this policy supports.

H-135.963	Recyclable and Reusable Utensils	Our AMA makes a commitment to use only reusable and recyclable utensils to the extent possible and encourages its constituent societies to do likewise. Citation: (Res. 608, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-135.966	Low-Level Radioactive Wastes	Our AMA (1) reiterates its endorsement of the process now in place for dealing with the disposal of low-level radioactive wastes, which involves the formation of compacts among the 50 states and the construction of regional facilities, and (2) encourages physicians to support and assist state agencies and others responsible for planning the safe disposal of low-level radioactive wastes. Citation: (BOT Rep. O, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind; superseded by H-135.989, "Low Level Radioactive Waste Disposal," which reads: "The AMA (1) believes that each state should be responsible for providing capacity within or outside the state for disposal of commercial, non-military low level radioactive waste generated within its border; and (2) urges Environmental Protection Agency action to ensure capacity for disposal of low-level radioactive waste.
H-135.992	Acid Precipitation	Our AMA encourages further scientific studies to determine the effects of acid precipitation on the population of the U.S. and Canada in order that the maximum impact of health professionals may be brought to bear toward the solution of this problem. Citation: (Res. 66, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-145.989	Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns	It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns. Citation: (Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.962	Air Bags and Preventing Crash Injuries	Our AMA (1) encourages the U.S. Department of Transportation to expand efforts to determine the efficacy of air bags in preventing serious injuries and the efficacy and safety of the air bag combined with the lap-shoulder belt in preventing such injuries; (2) encourages motor vehicle manufacturers to continue efforts to improve the safety of vehicles, focusing especially on active and passive restraints and strengthening passenger compartments; and	Retain; still relevant.

		(3) encourages physicians to take an active role in encouraging the use of automobile active and passive restraints among the general public, including infants and children. Citation: (BOT Rep. H, I-92; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11)	
H-15.967	Injuries Resulting from Pickup Trucks	Our AMA supports prohibiting any person from riding in the back of a pickup truck without the use of appropriate restraint devices and protection when the pickup truck is traveling on public roads. Citation: (Sub. Res. 15, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Rescind; superseded by Policy H-15.961, "Safety for Passengers in the Back of Pickup Trucks," which states that the AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck.
H-15.968	School Bus Safety and Braking and Steering Systems	Our AMA encourages (1) manufacturers of school buses to exceed the braking and steering system requirements of the U.S. Department of Transportation, making these systems as safe and easy to use as possible; (2) school bus manufacturers and federal agencies to continue their efforts to improve the safety of school buses and of school bus transportation programs, including driver education programs; and (3) physicians with an interest in children's problems, primary and secondary school education programs, or public health to evaluate pupil transportation systems in their own communities. Citation: (BOT Rep. N, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.992	Motor Vehicle Accidents	Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures. Citation: (BOT Rep. LL, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-15.993	Child Passenger Safety	Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts and (2) endorses and supports the efforts of other appropriate organizations to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in	Retain; still relevant.

		motor vehicles with appropriate restraining systems. Citation: (Res. 27, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation and Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-150.934	Competitive Eating	Our AMA recognizes competitive speed eating as an unhealthy eating practice with potential adverse consequences. Citation: (Res. 418, A-11)	Retain; still relevant.
H-150.967	Food Safety - Federal Inspection Programs	Our AMA encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety. Citation: (CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-150.969	Commercial Weight-Loss Systems and Programs	It is the policy of the AMA to (1) continue to cooperate with appropriate state and/or federal agencies in their investigation and regulation of weight-loss systems and programs that are engaged in the illegal practice of medicine and/or that pose a health hazard to persons to whom they sell their services; (2) continue to provide scientific information to physicians and the public to assist them in evaluating weight-reduction practices and/or programs; and (3) encourage review of hospital-based weight-loss programs by medical staff. Citation: (CSA Rep. A, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-150.990	Sodium in Processed Foods	Our AMA (1) encourages physicians to reinforce the profession's public education programs when counseling their patients; and (2) supports the efforts of food industries to achieve useful reductions in the sodium content of processed food, without compromising their safety or nutritive values. Citation: (CSA Rep. G, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, this policy is superseded by Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake," which states: Our AMA will: (1) Call for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and

			reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels. (2) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake. (3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.
H-150.997	Excess Sodium in the Diet	Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension. Citation: (Sub. Res. 22, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, this policy is superseded by Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake" (see above)
H-160.963	Community-Based Treatment Centers	Our AMA supports the use of community-based treatment centers for substance ~~ab~~use disorders, ~~emotional~~ mental health disorders and developmental disabilities. Citation: (BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant.

H-170.992	Alcohol and Drug ~~Abuse~~ Use and Addiction Education	Our AMA: (1) supports continued encouragement for increased educational programs relating to use of and addiction involving ~~abuse of~~ alcohol, cannabis ~~marijuana~~ and controlled substances; (2) supports the implementation of alcohol and ~~marijuana~~ cannabis education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol, cannabis products, and controlled substances. Citation: (Sub. Res. 63, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation and Reaffirmed: Sunset Report, I-00; Appended: Res. 415, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain in part to eliminate stigmatizing language. Remains relevant.
H-175.998	Evaluation of Iridology	Our AMA believes that iridology, the study of the iris of the human eye, has not yet been established as having any merit as a diagnostic technique. Citation: (CSA Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-185.969	Insurance Coverage for Immunizations	Our AMA endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles. Citation: (Res. 430, A-97; Reaffirmation A-01; Reaffirmation A-08; Reaffirmation A-11)	Retain, still relevant.
H-210.995	Home Health Care	The AMA (1) supports the concept of home health care as an alternative to hospital, nursing home, or other institutional care and as part of a total medical care plan; and (2) believes that home health care is an effective benefit to many patients. Citation: (BOT Rep. HH, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmation A-11)\	Retain, still relevant.
H-30.960	Physician Ingestion of Alcohol and Patient Care	Our AMA, believing that the possibility, or even the perception, of any alcohol-induced impairment of patient care activities is inconsistent with the professional image of the physician, (1) urges that physicians engaging in patient care have no significant body content of alcohol and (2) urges that all physicians, prior to being available for patient care, refrain from ingesting an amount of alcohol that has the potential to cause impairment of performance or create a "hangover" effect. Citation: (BOT Rep. Y, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain, still relevant.
H-30.961	Student Life Styles	Our AMA (1) supports educational programs for students that deal with t~~he problem of~~ alcoholism and drugs, and (2) encourages educational institutions to continue or institute efforts to eliminate the illegal and inappropriate use of	Retain in part to eliminate stigmatizing phrasing. Remains relevant.

		alcohol and other drugs on their premises or at their functions. Citation: (Res. 159, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-345.996	Physicians, Psychotherapy and Mental Health Care	Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public. Citation: (Res. 17, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain, still relevant.
H-370.989	State Regulation and Licensing of Human Tissue Banks	Our AMA encourages states to require licensing of human tissue banks in a manner consistent with the Food and Drug Administration's federal regulatory requirements. Citation: (Res. 68, I-87; Reaffirmed: Sunset Report, I-97; Modified: CSA Rep. 5, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. While still relevant, superseded by Policy H-370.988, "Regulation of Tissue Banking," which states: Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued

			involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues.
H-420.955	Nutrition Counseling for Pregnant and Recent Post-Partum Patients	Our AMA: 1) supports physician referrals of pregnant and post-partum patients for nutrition counseling, and 2) will advocate for the extension of health insurance coverage for nutrition counseling for all pregnant and recent post-partum patients. Citation: (Res. 409, A-11)	Retain; still relevant.
H-420.964	Fetal Alcohol Syndrome Educational Program	Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. Citation: (Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-420.965	Carrier Screening for Cystic Fibrosis	Our AMA: (1) supports the concept that participation in pilot studies or in any subsequent population screening program for cystic fibrosis (CF) be on a voluntary basis, with informed consent for all who wish to be tested; (2) encourages physicians to become more knowledgeable regarding genetic tests such as the one for CF, the interpretation of these tests, and genetic counseling; and (3) encourages physicians to become involved in educating the public about the nature of carrier screening for CF. Citation: (CSA Rep. C, A-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain as amended for clarity.
H-420.972	Prenatal Services to Prevent Low Birthweight Infants	Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants. Citation: (Res. 231, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 227, A-11)	Retain, still relevant.
H-420.992	Genetic Counseling and Prevention of Birth Defects	Our AMA believes that: (1) Adequate genetic counseling must be incorporated into any prenatal screening program established for the detection of birth defects and should be available both before and after the test is performed. (2) States should enhance their laboratory capability through broader utilization of those laboratories performing genetic screening~~, perhaps through regionalization of facilities so that karotyping of amniotic fluid cell cultures and their biochemical analysis can be more widely available~~.	Retain as amended for clarity.

		(3) Specialty societies should enhance their efforts to train physicians in the newer techniques of ante-natal diagnosis. ~~(4) Although the case for widespread carrier screening for common heterozygous abnormalities is far from established, pilot studies should be encouraged which will explore the cost-effective level of pre-natal testing in each locality.~~ Citation: (CSA Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-440.882	Secure National Vaccine Policy	Our AMA advocates for and supports programs that ensure the production, quality assurance and timely distribution of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention to the US population at risk. Citation: (Res. 709, I-04; Reaffirmation A-05; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11)	Retain, still relevant.
H-440.891	Support of ~~a~~ the n~~N~~ational Laboratory Response Network	Our AMA supports ~~the efforts of~~ the Centers for Disease Control and Prevention's ~~in establishing a~~ national ~~l~~Laboratory Response N~~e~~twork for communicating, coordinating, and collaborating with physicians and laboratory professionals on public health concerns. Citation: (Res. 516, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended for clarity.
H-440.894	Support of Four Principles of Hand Awareness	Our AMA: (1) endorses the Four Principles of Hand Awareness: (a) Wash your hands when they are dirty and before eating, (b) Do not cough into your hands, (c) Do not sneeze into your hands, and (d) Above all, do not put your fingers into your eyes, nose or mouth; and (2) encourages physicians to "adopt a school" in their communities and promote the Four Principles of Hand Awareness. Citation: (Res. 404, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-440.950	Premarital Testing	Our AMA encourages individual states to review and reassess the need for mandatory premarital testing for infectious diseases for their respective populations and to determine whether there is a favorable cost/benefit ratio for the specific disease in question. In the absence of a favorable ratio, states should consider abandoning mandatory premarital testing for an infectious disease. Citation: (BOT Rep. Z, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-440.972	Water Fluoridation	Our AMA: (1) urges state health departments to consider the value of requiring statewide fluoridation (preferably a comprehensive program of fluoridation of all public water supplies, where these are fluoride deficient), and to initiate such action as deemed appropriate; and (2) supports the 2011 proposed fluoridation standards as	Retain; still relevant.

		promulgated by the US Department of Health and Human Services and the Environmental Protection Agency. Citation: (Sub. Res. 9, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res 406, A-11)	
H-440.989	Continuation of the Commissioned Corps	Our AMA strongly supports the continuation of the Commissioned Corps of the US Public Health Service. Citation: (Res. 5, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-455.988	Public Education on the Danger of Radiation Exposure	~~1. Our AMA encourages the appropriate federal agency to develop a nationwide public education program on the effects of radiation exposure.~~ ~~2.~~ Our AMA supports public initiatives, such as the "Image Wisely" and "Image Gently" campaigns, which aim to increase awareness of radiation in the medical setting and reduce exposure. Citation: (Res. 121, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 921, I-11)\	Retain in part. The Health Resources and Services Administration (HRSA) developed the Radiation Exposure Screening & Education Program (RESEP).
H-455.993	Treatment of Radiation Accident Victims	Our AMA (1) encourages all acute care facilities, through their medical staffs, to review and become familiar with radiation accident contingency plans required by the JCAHO, particularly those facilities in areas where major radiation-emitting equipment is located; and (2) supports the development of guidelines for training and preparedness of medical staffs, proper treatment regimens and the maintenance and use of decontamination equipment for use at the time of radiation accidents. Citation: (Res. 36, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-460.907	Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients	Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients. Citation: (Res. 512, A-11)	Retain; still relevant.
H-470.985	Goalie Face Masks in Hockey	Our AMA endorses the mandatory use of an adequate cage-type face mask for goalies in all amateur, high school and college hockey programs in the nation. Citation: (Res. 4, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.

H-470.986	Helmets for Hockey Referees	Our AMA endorses the use of hockey helmets for all referees in amateur, high school and college hockey programs in the US. Citation: (Res. 123, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-470.991	Promotion of Exercise	1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. Citation: (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11)	Retain; still relevant.
H-480.951	Fingerstick And Single-Use Point-of-Care Blood Testing Devices Should Not Be Used For More Than One Person	Our AMA encourages improved labeling of fingerstick and point-of-care blood testing devices such that it is clear that multiple-use fingerstick devices made for single patients are intended for use only on single patients. Citation: (Res. 515, A-11)	Retain; still relevant.
H-480.981	Cryotherapy, Therapeutic Ultrasound and Diathermy	Our AMA recognizes that the application of heat or cold is a therapeutic modality used by a variety of practitioners. When these modalities are used and are expected to cause tissue destruction, the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician. Citation: (BOT Rep. P, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-490.916	Health Insurance and Reimbursement for Tobacco Cessation and Counseling	Our AMA: (1) (a) continues to support development of an infrastructure for tobacco dependence treatment; (b) will work with the U.S. Public Health Service, particularly the Agency for Health Research and Quality, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction; (c) urges third party payers and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; and (d) supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts; (2) (a) requests Congress to provide matching	Retain, still relevant.

		funds for Medicaid coverage for evidence-based programs and Food and Drug Administration (FDA)-approved products that lead to smoking cessation; and (b) seeks the requirement that state Medicaid programs, prepaid health plans, and insurance companies provide evidence-based approaches for smoking cessation and nicotine withdrawal, including FDA-approved pharmacotherapy, as part of their standard benefit packages. Citation: (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Reaffirmation A-11)	
H-495.983	Tobacco Litigation Settlements	Our AMA: (1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco companies or tobacco products. Citation: (CSA Rep. 3, A-04; Reaffirmation I-11)	Retain, still relevant.
H-50.995	Voluntary Donations of Blood and Blood Banking	Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply;	Retain; still relevant.

		(2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science; (3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and (4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. Citation: (BOT Rep. V, A-71; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res. 507, A-98; Appended: CSA Rep. 4, I-98; Reaffirmed: CSA Rep. 1, A-99; Amended & Appended: Res. 519, A-01; Modified: CSAPH Rep. 1, A-11)	
H-525.985	Safety and Performance Standards for Mammography	Our AMA actively encourages the development of new activities, and supports the coordination of ongoing activities, to ensure the following: (1) that the techniques used in performing mammograms and in interpreting mammograms meet high quality standards of performance, including evidence of appropriate training and competence for professionals carrying out these tasks; (2) that the equipment used in mammography is specifically designed and dedicated. The performance of mammography imaging systems is assessed on a regular basis by trained professionals; (3) that the American College of Radiology Breast Imaging Reporting and Database System is widely used throughout the United States and that mammography outcome data in this database are used to regularly assess the effectiveness of mammography screening and diagnostic services as they are provided for women in the United States; and (4) regular breast physical examination by a physician and regular breast self-examination should be performed in addition to screening mammography. Citation: (BOT Rep. JJ, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-525.986	Guidelines and Medicare Coverage for Screening Mammography	Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening mammography in women over 64 years of age.	Retain, still relevant.

		Citation: (BOT Rep. CC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-60.928	Body Image and Advertising to Youth	Our AMA encourages advertising associations to work with public and private sector organizations concerned with child and adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image. Citation: (Res. 413, A-11)	Retain; still relevant.
H-60.929	National Child Traumatic Stress Network	Our AMA: 1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative ~~at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network~~. Citation: (Res. 419, A-11)	Retain in part, the FY 2011 level mentioned is outdated and should be deleted.
H-60.955	Screening Pediatric and Adolescent Injury Victims for Drugs and Alcohol	Our AMA: (1) supports drug and alcohol screening as an appropriate component of a comprehensive medical evaluation for pediatric and adolescent injury victims when clinically indicated; and (2) encourages physicians to actively pursue appropriate referral and treatment when clinically indicated for all pediatric and adolescent injury patients who test positive for the presence of drugs or alcohol. Citation: (Res. 408, I-94; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-60.971	Removal of High Alcohol Content from Medications Targeted for Use by Children and Youth	Our AMA encourages pharmaceutical companies to limit the alcohol content of their medications to the minimum amount necessary as determined solely by the physical and chemical characteristics of the medication. Citation: (Sub. Res. 507, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain; still relevant.
H-60.974	Children and Youth With Disabilities	It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and	Retain; still relevant.

		youth with disabilities receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations. Citation: (CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	
H-60.976	Genetic and Medical History of the Adopted	It is the policy of the AMA (1) to assist the appropriate bodies to develop a medical and genetic history form which would become, and remain, protected information and part of an adopted individual's permanent record on their entry into the fostercare/adoption system; and (2) to draft model state legislation which clearly mandates all appropriate agencies to furnish to the adoptive parents, when possible, the appropriate medical and genetic family history furnished by birth parents, with a mechanism to protect the confidentiality of all parties. Citation: (Res. 512, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Rescind. Medical and genetic history forms exist and are now readily available on many websites discussing adoption, including the CDC website. Additionally, the AMA developed model state legislation "To Require the Provision of the Genetic and Medical History of The Adopted to Adoptive Parents."
H-75.990	Development and Approval of New Contraceptives	Our AMA (1) supports ~~congressional~~ efforts to increase public funding of contraception and fertility research; (2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices; and (3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA. Citation: (BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)	Retain in part.
H-75.992	Family Planning Clinic Funds	Our AMA supports the concept of adequate funding for family planning programs. Citation: (Res. 102, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: Res. 227, A-11)	Retain; still relevant.

H-90.996	Education of Children with Disabilities ~~Handicapped Children~~	Our AMA supports efforts to ensure an appropriate role for physicians in the development of special education programs for ~~handicapped~~ children with disabilities. Citation: (BOT Rep. I, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended to eliminate stigmatizing term.
H-95.963	Standardization of Collection and Custody Procedures of Body Fluid Specimens	~~It is the policy of t~~The Our AMA ~~to seek to have~~ supports the use of standardized procedures, containers and forms ~~developed that will~~ to satisfy the requirements of all requesting entities ~~which will reduce the hassle which currently exists in~~ for processing specimens of body fluids for drug testing ~~screens~~ and for insurance applications. Citation: (Res. 501, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended as standardized procedures have been outlined.
H-95.965	Residential Treatment for ~~Drug-Addicted~~ Women with Substance Use Disorder	Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. Citation: (Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain as amended to eliminate stigmatizing term.
H-95.978	Harmful Drug ~~Abuse~~ Use in the United States - Strategies for Prevention	Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors. (2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol ~~ab~~use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills. (3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol ~~ab~~use. (4) Supports the development of advanced educational programs to produce qualified	Retain in part to eliminate stigmatizing language. Remains relevant.

		prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations. (5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities. (6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug ~~ab~~use. Citation: (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)	

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June 2021)
Addressing Increases in Youth Suicide
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families, peers, and communities. Youth and young adult suicide rates rose 54.7 percent from 2007 to 2018 even before the major behavioral and psychological disruptions caused by the COVID-19 pandemic.[1] Despite a small decrease in suicide mortality in 2018 and 2019 data, suicide deaths in youth and young adults overall have been steadily increasing since 2007 and in 2019 suicide was the second leading cause of deaths among those 10-24 years of age.[2] Due to the alarming increase in suicide and suicide risk in youth and young adults, the Council on Science and Public Health initiated this report to further examine this issue and to provide relevant updates to American Medical Association (AMA) policy.

Methods. English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms "teen," "youth," and "adolescent," coupled with "suicide," "suicide contagion," "suicidal ideation," "and "suicidal thoughts and behavior." Related search terms linked with the above were "mental health," "substance use," "trauma," "ACEs," "LGBTQ," and "bullying." Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. Increases in suicides and suicide attempts have occurred among both male and female youth, with males using more lethal means such as firearms in completed suicides. Youth and young adults in the Native American/Alaska Native demographic groups show the highest number of completed suicides and attempts. Increases in instances of cyberbullying are an important factor associated with youth suicide and requires additional attention. Increases in screen time and in the use of digital devices, the internet, and social networking sites are associated with decreases in time sleeping and increases in depression. Additionally, stresses and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for some youth and possibly increased suicidal ideation. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), substance use disorder, adverse childhood experiences, or other stressors are present, the risk for suicidal thoughts or behavior increases.

Conclusions. Enhancing physician capability and capacity to screen for, identify, and respond to risk factors for youth suicide are essential to effective suicide prevention efforts. Physicians who see patients in these age groups, and not solely pediatric psychiatrists and addiction medicine physicians, should have access to the tools to identify acute risk and respond with appropriate clinical interventions, linkages to appropriate counseling services, and safety planning. They should also be able to identify and promote relevant protective factors to mitigate the impact of underlying risk factors. Collectively, physicians, parents, teachers, peers, clergy, youth ministers, social workers, counselors, and others, are critical in identifying when a young person is experiencing a period of imminent risk and assisting in preventing suicide attempts.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-JUN-21

Subject: Addressing Increases in Youth Suicide

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

INTRODUCTION

In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families and communities. Suicides and suicide attempts among youth, ages 10-24 have increased steadily since 2007. Data shows that although suicides remained relatively stable in this age group from 2000 to 2007, rates started to rise in 2007 and increased 54.7 percent through 2018.[1] While we do not yet know the full impact of the COVID-19 pandemic on youth suicide, the potential mental health consequences of COVID-related stressors are of concern. As a result of the steady increase in youth suicides, the Council on Science and Public Health initiated this report to understand current risk and protective factors, examine evidence-based interventions for youth and young adult suicide, and to update American Medical Association (AMA) policy accordingly.

The focus of this report will be on children, adolescents, and young adults age 10-24, hereinafter referred to in this report as youth. Data and trends in suicide in populations beyond this age group, while important, are outside the scope of this report.

METHODS

English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms “teen,” “youth,” and “adolescent,” coupled with “suicide,” “suicide contagion,” “suicidal ideation,” “and “suicidal thoughts and behavior.” Related search terms linked with the above were “mental health,” “substance use,” “trauma,” “ACEs,” “LGBTQ,” and “bullying.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Much of the literature reviewed for this report uses the term “suicidal thoughts and behavior” or “STB” as shorthand to describe suicidal thoughts, ideation, planning, and suicide attempts. Non-suicidal self-injury (NSSI) is differentiated in the literature in the United States whereas in Europe it might be included as an STB. For the purposes of this report, the abbreviation STB will be used to mean suicidal thoughts, suicidal ideation and planning, and suicide attempts.

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BACKGROUND

Addressing youth suicide is a critical and growing public health issue. Suicides in the United States rose since 2000, increasing 30 percent from 2000 to 2016, with rates increasing among all age groups in the 10-24 range and across 42 states. Rates of suicide in the 10-24 age group have risen 57.4 percent from 6.8 per 100,000 in 2007 to 10.7 per 100,000 in 2018. In 2017 approximately 2.4 percent of all students in grades 9-12 reported making a suicide attempt that required treatment by a physician or nurse.[3] Suicide was the second-leading cause of death for young people ages 15 to 24, second only to accidents in 2019.[2] While more recent data suggest there was a modest decrease in youth suicide in 2018 and 2019, overall levels of suicide among youth are still significantly higher than they were ten years before. And since 2019 stress on youth as well as adults has increased in the wake of the disruption associated with the COVID-19 pandemic, such as physical distancing and social isolation[1,2,4,5]

Total mortality of youth from suicide in 2017 was 6,200 deaths in those age 10-24, with that number rising to 6,807 in 2018.[6] Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance Survey (YRBSS) data from 2019 show that more high school students were contemplating suicide, rising from 13.8 percent in 2009 to 18.8 percent in 2019.[7] Of all high school students in 2019, 8.9 percent reported having attempted suicide, with prevalence estimates highest among females (11.0 percent) and black non-Hispanic students (11.8 percent).[3] Completed suicides are more common in males at rates two to four times higher than females, but suicide attempts are 3-9 times more common in females overall.[8,9] From 2009 through 2019, prevalence of suicide attempts increased overall and particularly increased among female, non-Hispanic white, non-Hispanic black, and 12th-grade students.[7,10]

STB varies by race and ethnicity among youth. Native American Indian/Alaska Natives have had the highest suicide rate over the last 20 years. While suicide rates have historically been higher among White individuals than Black individuals, data suggests that suicide risk is increasing among Black youth. One study showed higher incidence of STB for Black youth in the 5-12 age group than White counterparts.[11] There is data showing overall increase in the rate of STB among Black youth age 12-17 through the period of 1991-2017, while rates for STB among White youth in that age group have decreased.[10] Rates of STB in Hispanic/Latinx female young adults also increased between 2000 and 2015.[12,13] In addition, sexual and gender minority youth are more likely to engage in suicidal behavior than their non-LGBTQ peers. It is important to understand the impact of structural racism, historical trauma, and accumulative stress on mental health in minority and historically marginalized communities, may contribute to depression and other risk factors for STB.[14-16]

In 2019 firearms were the leading cause of suicide death in those age 15-24 and the second leading cause of suicide death for those in the 10-14 age group. Suffocation is the other leading cause of suicide death among those 10-24. Firearms as a means of suicide have trended upward for young females and deaths from poisonings have decreased.[2,5] In 2018, the Council on Science and Public Health released a report adopted by the House of Delegates on "The Physician's Role in Firearm Safety and recognized the role of firearms in suicides and encouraged physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.[17]

CURRENT AMA POLICY

Highlights of AMA policy related to youth suicide include recognizing teen and young adult suicide as a serious health concern Policy H-60.937, "Teen and Young Adult Suicide in the United

States." Policy D-350.988, "American Indian / Alaska Native Teen Suicide" encourages significant funding for suicide prevention and intervention directed toward American Indian/Alaska Native communities. Policy H-60.927, "Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations," also recognizes the special risk for LGBTQ+ teens and calls for partnering with public and private organizations to help reduce suicide among these teens. Policy H-515.952, "Adverse Childhood Experiences and Trauma-Informed Care," recognizes the importance of trauma-informed care and the impact of adverse childhood experiences (ACEs) and trauma on patient health.

Policy H-60.911 "Harmful Effects of Screen Time in Children" encourages physicians to "assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits" and to advocate for education in schools about balancing screen time, physical activity, and sleep. Policy H-515.959 "Reduction of Online Bullying" addresses this urging social networking platforms to" define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging" as part of their Terms of Service agreements. In addition, Policy H-60.943 "Bullying Behaviors Among Children and Adolescents" addresses bullying in several ways, including urging physicians to be aware of the signs and symptoms of bullying in children and teens, to recognize the mental, emotional and physician effects of bullying and to counsel patients and parents on effective interventions and coping strategies.

RISK FACTORS FOR YOUTH SUICIDE

Various behavioral, emotional, psychological, and social risk factors for youth suicide have been well established, and include depression, anxiety, bullying, substance use disorder (SUD), trauma, family history of suicide, sexual orientation or sexual and gender minority status and other stressors.[18,19] Prior suicide attempts are one of the most serious indicators of risk for subsequent self-harm and suicidal behavior.[20] Over 30 percent of youth suicides are preceded by a prior attempt, with boys with previous suicide attempts having a 30-fold increase for risk of a subsequent attempt in comparison with boys with no prior attempts. Girls with previous suicide attempts show a 3-fold increase in risk for subsequent attempts in comparison to girls with no prior attempts.[8] The presence of multiple factors increases underlying risk. Prevention starts with a thorough understanding of risk factors. Identifying risk factors is essential but does not provide the ability to predict acute suicidality effectively and accurately. Underlying risk factors can exist for years without producing active suicidality and imminent risk of suicide, and no one risk factor alone can be an absolute predictor.[18,19,21]

Role of Mental Health Disorders

Suicide is closely linked to mental health disorders, mainly depression and other mood disorders.[22,23] Among all age groups, approximately 90 percent of people who complete a suicide have had at least one mental health disorder.[24] Risk is significantly increased for acute suicidality when there are psychotic symptoms and when there are family members who have mental health or SUD issues.[25,26]

Data shows that depression in youth has been on the rise from 2005 to 2019. The 2019 National Survey on Drug Use and Health (NSDUH) indicates that among teens aged 12-17, rates of major depressive disorder increased 52 percent during the period between 2005 and 2017, and an increase of 63 percent was seen in young adults aged 18-25. Those trends were also accompanied by increases in reports of serious psychological distress and suicide related outcomes (STB and

suicide mortality) with a dramatic increase of 71 percent for those aged 18-25.[27] More recent statistics show that reports of suicidal ideation, planning, persistent feelings of hopelessness and sadness in high school students rose consistently from 2009 to 2019. More high school aged teens were injured in a suicide attempt during that period as well.[7] Other trends from 2009 to 2019 include the rise of electronic devices and digital media as well as declines in sleep which may be contributors to depression and other mood disorders.[27] Lack of availability of mental health services is also a concern. Youth who live in urban and suburban areas have been shown to have greater access to mental health resources than teens who live in rural areas.[28] When mental health disorders are not properly addressed, the risk for suicide can increase dramatically.[19,29]

Substance Use Disorder

Substance use is a major predictor of STB in youth.[30,31] Studies have shown that youth who used substances (tobacco, alcohol, cannabis, MDMA, ketamine) exhibit more suicidal behavior. In general, historically, boys exhibit more serious substance use, for example, using alcohol and drugs in larger quantities, with more frequency, and starting at an earlier age than girls. The association between substance use and suicidal behavior, however, is consistent between males and females.[30]

Adverse Childhood Experiences (ACEs)

ACEs, including physical, mental, and sexual abuse, physical and emotional neglect, and household dysfunctions such as family mental illness, violence, incarceration, substance use, and divorce, are well documented risk factors for suicide and according to the CDC, are associated with at least five of the ten leading causes of death overall. The higher the number of ACEs experienced, the greater the risk for suicide, and for youth, the risk is greater than in adults. A 2001 study found that an ACE score of 7 or more increased the risk of suicide attempts 51-fold among youth and 30-fold among adults. The study also found that between various forms of abuse, emotional abuse in childhood was the greatest predictor of future suicide attempts and the least addressed by traditional child welfare systems. ACEs increase risk for suicide as well as negative opioid-related outcomes, including overdose. These risk factors due to ACEs are preventable and require urgent attention.[32-34]

COVID-19 Pandemic

The COVID-19 pandemic has impacted youth STB and mental health. According to CDC data, from April 2020, the proportion of youth mental health-related emergency department (ED) visits increased and remained elevated through October of 2020. Compared with 2019, the proportion of mental health-related visits for youth aged 12-17 years increased approximately 31 percent. Studies have also identified increased rates of suicide ideation and suicide attempts in 2020 during the COVID-19 pandemic as compared with 2019 rates. The increases correspond to times when COVID-related stressors and community responses were heightened. This increase was seen across demographics in the 11-21 age group and based on routine suicide risk screens in a pediatric ED setting.[35,36]

Stigma

Ample evidence exists related to the negative impact of stigma on mental health. Youth learn stigmatizing attitudes from many sources including parents, peers, and media and start to concretize their attitudes in adolescence. Recognition of mental health stigma as a barrier to care for youth is essential for targeted suicide prevention efforts. In addition, myths around suicide

contribute to stigma. Characterization of people who experience STB as "weak" or "cowardly" perpetuate stigma and can inhibit youth from asking for help.[37-39]

Increased Screen Time and Use of Digital Devices Linked to Depression

The increased use of digital devices and social media can be linked to increases in mental health symptoms, including depression, among youth grades 8-12. Use of social media and digital devices also have an association with increases in youth suicides from 2010 to 2015. A review of several studies on social media/internet use and suicide attempts found consistent associations between heavy internet/social media use and suicide attempts of those under the age of 19.[40] Depressive symptoms, which have a strong correlation with STB, increased together with screen time and social media use. Moreover, youth who spent less time onscreen and on smartphones and more time on non-screen activities (in person visiting, sports, religious activities, reading) reported fewer depression symptoms and suicidal thoughts.[40,41]

Bullying and Cyberbullying

Although cyberbullying is a new area of research, several investigators report associations with both emotional and physical variables, including loneliness, anxiety, depression, suicidal ideation, and somatic symptoms. Also linked to cyberbullying is an increased risk of STB and self-harm for victims, and an increased risk of STB for perpetrators.[42-45]

The effects of bullying can be magnified and intensified by youths' access to social media, where the typical number of peers in a school and community circle is now expanded to any youth who has access to the internet and social networking sites. Several examples of tragic stories exist in the media of cases where victims experienced repeated instances of bullying that that were widely spread over the internet and social media. Teens left behind messages indicating they felt hopeless that the bullying would stop.[46]

A 2013 review of resources for cyberbullying examined interventions and prevention strategies acknowledge that many resources have been developed, but that there must be more research to determine effectiveness and how best to tailor programs to various school settings.[47] An online cyberbullying information clearinghouse, The Cyberbullying Research Center, provides guides to state laws on cyberbullying, research, and resources for parents, educators, youth and health care providers on addressing cyberbullying.[48]

Suicide Contagion/Clusters

Suicide clusters consist of episodes of multiple suicides that are greater than what would be typical in a specific location, many times in quick succession, and are more common in young people (<25 years) than adults. Approximately 1-5 percent of youth suicides occur in a cluster after a youth dies by suicide. Suicide contagion, which is triggered by exposure to a death by suicide, can increase the risk of suicide in another and has been shown to be a significant factor in youth STB.[49] The colloquial term often used for this phenomenon is "copy-cat suicide." Suicide contagion can result from direct exposure such as a suicide of a family member, friend, or classmate or indirect exposure through media or online reports. Youth are especially sensitive to peers' thoughts and expressions and may be more impacted by media reporting on suicide, suicide clusters, and exposure to a suicidal peer. A study showing a 28.9 percent spike in youth (ages 10-17) suicide across the United States in the months following the release of the fictional Netflix series "13 Reasons Why," is an example of the influence of media; the show follows a fictional character who ultimately dies by suicide.[50]

Media depictions or social networking posts that romanticize youth suicide may result in suicide contagion and clusters.[51-56] Guidelines for the media on responsible reporting on suicides for media are available including a collaboratively produced guide called "Recommendations for Suicide Reporting" and the International Association for Suicide Prevention's (IASP) guide "Preventing Suicide: A Resource for Media Professionals" outlining numerous "dos and don'ts" for media in reporting on suicide. Among the points of guidance are not using language which sensationalizes or normalizes suicide; not presenting suicide as a constructive solution to problems; avoiding explicit descriptions of the method(s) used in a completed suicide; and using sensitivity when interviewing family and friends of suicide victims.[57,58]

Developmental Characteristics of Adolescence That Increase Vulnerability

Impulsivity in young people is typical and has been shown to be a factor in their vulnerability to suicidal impulses. Research has found that emotion-relevant impulsivity as well as poor control over emotional reactions are more prevalent in adolescence. A type of emotion-relevant impulsivity, negative urgency, which is a strong and immediate need to avoid unpleasant emotions or physical sensations, is a distinct form of impulsivity and is a strong predictor of problem behaviors and STB.[59] Underdevelopment of the prefrontal areas of the brain and discordant development in the prefrontal and limbic systems are thought to be linked to teen risk taking and impulsivity. The drive to reward seeking without effective inhibitory controls results in a variety of negative outcomes driven by impulsive behaviors, including STB.[60,61]

PROTECTIVE FACTORS

Enhancing resiliency and identifying protective factors are important ways to mitigate risks for youth suicide. Protective factors include connectedness to supports such as peers, family, community and social institutions, life skills, coping skills access to behavioral and mental health care, and cultural, religious, or personal beliefs that discourage suicide. There are many resources on ways to enhance resiliency in youth that help mitigate suicide risk including developing a positive identify, and age-appropriate empowerment. The Interagency Working Group on Youth Programs composed of representatives from 21 Federal agencies, has a multitude of web-based resources designed to support positive youth development.[62-64]

PREVENTION

School Based Suicide Prevention Programs

School based suicide prevention programs fall generally into several categories; suicide awareness and prevention trainings for school personnel, universal suicide prevention curriculum for all students, and targeted or selected interventions for students who are identified as at risk.

Reviews of research in these areas show that there are some benefits in all these approaches, but there is wide variability in methodology and outcome measurements. Research shows that effectiveness of school-based programs has not been well established yet in terms of impact on primary outcomes (numbers of suicides). More recent reviews of studies on school-based programs literature calls for continued and better research to determine which interventions or which combination of interventions are most effective in preventing suicides.[65,66]

Screening

The U.S. Preventive Services Task Force (USPSTF) examined the evidence to determine whether asymptomatic youth should be screened for suicide risk in their 2013 report and found the evidence to clearly establish risks and benefits to be insufficient.[67] However, the USPSTF does recommend that primary care clinicians screen youth for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up. USPSTF also recommends primary care clinicians provide increased focus for their patients during periods of high suicide risk, such as immediately after discharge from a psychiatric hospital or after an emergency department visit for deliberate self-harm. Recent evidence suggests that interventions during these high-risk periods are effective in reducing suicide deaths.[68-70] Experts in youth suicide prevention note that effective screening can be a simple conversation beginning with the question: "Are you OK?"[69]

Currently, there is no recommendation from the American College of Emergency Physicians to institute widespread screening for suicide in Emergency Departments (ED). Some evidence notes that EDs are an ideal place for expanding screening since many youths visit an ED at some point during adolescence. A study using a computerized screening tool, the Computerized Adaptive Screen for Suicidal Youth (CASSY), designed for teens aged 12-17 having an ED visit, accurately predicted a suicide attempt within a three-month period following the ED visit.[71]

The Joint Commission

The Joint Commission has developed seven new and revised elements of performance in accreditation surveys applicable to hospitals, behavioral health care organizations, and accredited critical access hospitals. These new elements are designed to "improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide." The revised elements involve environmental risk assessment, use of validated screening tools, evidence-based screening for suicide risk, documentation of overall risk for suicide and mitigation plans, written policies (staff training, reassessment, monitoring high-risk individuals), follow up care, and monitoring whether procedures are effective. It is important to note however, that the new elements of performance for accreditation surveys do not explicitly require that all patients in hospital settings be screened. Despite the allowance for selective screening, some hospital care settings have instituted universal screening of patients and the feasibility of this is an ongoing debate. Other accrediting bodies, specifically the Council on Accreditation (COA) and Commission on Accreditation of Rehabilitation Facilities (CARF), have also made changes to their standards for facilities related to suicide prevention. The movement in this direction will eventually require some adaptation in health care facilities to these new elements.[72]

The Joint Commission recommends several evidence-based screening tools for assessing suicide risk in accredited organizations. They include the Columbia Suicide Severity Rating (C-SSR), the Ask Suicide-Screening Questions (ASQ), and the Suicide Behaviors Questionnaire-Revised (SBQ-R). The Patient Health Questionnaire (PHQ-9) is also recommended as a depression screening tool and scale to determine severity. [73,74]

Targeted Prevention Efforts

Statistics note that special attention to targeted prevention efforts could be important for sub-populations of youth that are showing higher risk than others for STB. This includes Native American and Native Alaskan males, Black youth, LGBTQ+ teens, and Latina youth. The National Suicide Prevention Lifeline website devotes a page to resources for Native American and Alaskan

populations. All these youth sub-populations could benefit from targeted prevention efforts that are culturally sensitive and community based.[75-77]

INTERVENTIONS

Access to Mental Health Care

Reportedly, less than half of young people who have died by suicide had received psychiatric care. Increased access to mental health services is needed in addition to community supports, peer supports, school-based programs, college counseling services and social services designed to prevent youth and young adult suicide.[23] Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a suicide prevention resource list of guides, crisis lines, and prevention programs for children and youth.[78]

Medications

Medications used to treat mental health conditions can alleviate symptoms and hopefully mitigate risk of STB. Evidence exists that treatment with antidepressants can result in lower suicide rates overall.[79,80] Evidence is also available that indicates lithium and clozapine can directly lower suicidal behavior, however the use of these medications is limited because of the time needed to reach therapeutic levels and the narrow therapeutic index of each of these agents. Anxiolytics, sedative-hypnotics, and some antipsychotic medications can be utilized to decrease agitation, anxiety, distress, insomnia, and other symptoms of psychological distress in an acute situation.[79,81]

An esketamine nasal spray for depression was recently approved by the US Food and Drug Administration (FDA) for use in adult patients who are contemplating suicide and shows promise for relieving acute suicidality and rapidly improving depressive symptoms. Esketamine can relieve symptoms within 24 hours, as opposed to typical antidepressants which can take up to 3-4 weeks to relieve symptoms. This medication is approved for use in adults only. The American Academy of Child and Adolescent Psychiatry (AACAP) has made a statement reiterating that it is not approved by the FDA for use in pediatric patients and cautioning physicians about off-label use.[82-84] Recently, the National Institute of Mental Health (NIMH), released a research update stating that they are supporting multiple new research projects on ketamine and esketamine as well as transcranial magnetic stimulation (TMS) for safety, efficacy and feasibility in youth and young adults who are acutely suicidal. TMS uses magnets to stimulate specific parts of the brain. Both these interventions could produce rapid decrease in severe suicidal thoughts and feelings.[85]

Specific Psychotherapies

Among psychotherapeutic models, cognitive behavioral therapy (CBT) has the most evidence of effectiveness in youth and adults for a variety of disorders, particularly anxiety and depression.[86] Internet based CBT (iCBT) has also been studied and consistently shows some efficacy in reducing suicide attempts. iCBT has also shown some efficacy in reducing both SUD and STB in youth and is potentially a highly scalable intervention.[87,88] Additionally, YST-II, a social support program, shows promise in reducing suicidal ideation in youth following a suicide attempt.[89] A 2018 report of two independent trials on Dialectical Behavioral Therapy (DBT), showed promise for effectiveness with youth experiencing STB.[90] More research is needed to fully understand the utility of psychotherapies.

FEDERAL EFFORTS TO REDUCE YOUTH SUICIDE

US Department of Health and Human Services

Office of the Surgeon General. Efforts to prevent adult and youth suicide at the federal level in the United States have been led by the U.S. Surgeon General going back to 2001. The National Strategy for Suicide Prevention (NSSP) was the first organized and comprehensive effort on suicide prevention, with the latest revision done in 2012. The NSSP contains four strategic directions that each include a set of goals and objectives: (1) Create supportive environments that promote healthy and empowered individuals, families, and communities (4 goals, 16 objectives); (2) Enhance clinical and community preventive services (3 goals, 12 objectives); (3) Promote the availability of timely treatment and support services (3 goals, 20 objectives); and (4) Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives). The NSSP's four strategic directions are meant to work together in a synergistic way to prevent suicide in the nation.

In January of 2021, the Surgeon General released a "Call to Action to Implement the National Strategy for Suicide Prevention," an effort to broaden perceptions of suicide, who is affected, and recognition of the environmental factors as well as individual factors related to suicide risk.[91,92]

SAMHSA. The National Suicide Prevention Lifeline has been in operation since 2005 and is funded by SAMHSA in partnership with the National Action Alliance for Suicide Prevention (Action Alliance[93]), The National Suicide Prevention Lifeline is a network of over 160 independently operated crisis call centers nationwide that are linked to a series of toll-free numbers, the most prominent of which is 800-273-TALK. In July 2020, the Federal Communications Commission (FCC) designated the three-digit number 988 for the National Suicide Prevention Lifeline to aid rapid access to suicide prevention and mental health services.[75,93]

Additionally, SAMHSA recently released an evidence-based guide, "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth." This guide is targeted to healthcare professionals and a broad range of stakeholders and details the strategies for addressing suicidal ideation, self-harm, and suicide attempts among youth. The guide highlights psychotherapeutic models that have shown evidence of effectiveness in reducing one or more of the outcomes of suicidal ideation, self-harm (non-suicidal), self-harm (unknown intent), and completed suicides.[75,89,93]

CDC. The CDC has created a comprehensive technical package of strategies that can be implemented by communities and states that include strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk. Also, the CDC has recently released information showing the increased risk for suicide and negative opioid related outcomes (including overdose) associated with ACEs.[33,62]

FEDERATION OF MEDICINE EFFORTS

Several medical specialty societies have addressed youth suicide. The American Academy of Pediatrics (AAP) has developed web-based downloadable targeted at teens and their parents/caretakers on mental health as well as identifying suicide risk and creating emotional well-being in teens and children.[94] Other societies including the American College of Emergency Physicians (ACEP), American Association of Family Physicians (AAFP), the American

Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) all have patient resources, policies, clinical guidance, or public statements addressing depression and identifying imminent risk for STB in youth and adults.[50,94-97]

A 2021 joint summit on teen suicide co-hosted by the AAP, the American Foundation for Suicide Prevention (AFSP), and the National Institute for Mental Health (NIMH), brought forth several recommendations including the need for early identification of suicide risk, screening/assessment, follow up, and counseling. Other recommendations included the importance of widespread screening for youth seen in the ED for any reason and using a strengths-based and culturally sensitive approach to help youth disclose possible suicidal thoughts and ideation. A focus on prevention efforts, along with better data on their effectiveness for sub-populations (Black, Indigenous/Alaska natives, and LGBTQ youth) was also highlighted. A suicide prevention blueprint document from the summit is scheduled to be available later in 2021.[98]

EMERGING AREAS OF RESEARCH

Medications

New medications for acute STB are being developed and experts have called for increased utilization of existing medications. Leading experts encourage continued research to understand the neurobiology of suicide, including the identification of biomarkers and neuropsychological vulnerabilities associated with acute suicidality.[79,99] A better understanding of the neuropathophysiology of suicide can assist in the development of new medications for treatment.

Digital Technology and Machine Learning

The National Institutes of Health is funding research into the Mobile Assessment for the Prediction of Suicide (MAPS) as a way of using machine learning to detect suicide risk. These risk prediction algorithms can be embedded in digital devices such as smartphones, tablets, and laptops, and show promise in detection of near and imminent risk.[100]

Imminent Risk-Warning Signs

One of the most significant challenges of reducing suicides in youth, as in all demographics, is detecting windows of acute and imminent risk. While many of the risk factors for suicide in young people are understood, the ability to predict imminent risk effectively is lacking. Signs of imminent risk include talking about wanting to die, asking how one will be remembered, seeking out means of suicide, talking about feeling hopeless, expressing feelings of being trapped in unbearable pain, increased misuse of alcohol or drugs, increased agitation, withdrawal, mood dysregulation, and giving away treasured items and belongings.[19,69]

CONCLUSION

Suicides are increasing among both male and female adolescents, with males using more lethal means such as firearms in completed suicides and attempts. The young Native American/Alaska Native demographic group has the highest number of completed suicides and attempts among all youth. Increases in instances of cyberbullying are an important factor that are associated with youth suicide and require additional attention. Increases in screen time and use of digital devices, internet, and social networking sites have been associated with decreases in time sleeping and increased depression. Additionally, stress and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for all cohorts, including young

people and increased suicidal ideation in some cases. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), SUD, ACEs, or other stressors are present, risk for STB increases. [29,41,70]

Enhancing physician ability and capacity to screen, identify and respond to risk factors are an important feature of effective suicide prevention for youth, especially for those physicians who are more likely to encounter these patient populations. Physicians should have access to the tools to identify acute and imminent risk and respond with appropriate treatments, linkages to appropriate counseling services, collaboration, and safety planning. Collectively, parents, teachers, peers, physicians, social workers, faith communities, counselors, and others, are critical in identifying when an individual is experiencing a period of imminent risk and assisting in preventing suicide attempts.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That Policy H-60.937 be amended to read as follows:

~~Teen~~ Youth and Young Adult Suicide in the United States

Our AMA:

(1) Recognizes ~~teen~~ youth and young adult suicide as a serious health concern in the US;

(2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;

(3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;

(4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;

(5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Latino, and Indigenous/Native Alaskan youth and young adult populations;

(6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults; and

(7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools. (Modify Current HOD policy)

2. That Policy H-515-952, "Adverse Childhood Experiences and Trauma-Informed Care" be amended by addition to read as follows:

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:
   a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
   b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
   c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
   d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; ~~and~~
   e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
   f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes. (Modify Current HOD policy)

3. That Policy H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," which recognizes the role of firearms in suicides; encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling; and encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide, be reaffirmed. . (Reaffirm Current HOD Policy).

4. That Policy H-170.984, "Healthy Living Behaviors," encouraging state medical societies and physicians to promote physical and wellness activities for children and youth and to advocate for health and wellness programs for children and youth in schools and communities, be reaffirmed. (Reaffirm Current HOD Policy)

Fiscal note: Less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(JUN-21)

Introduced by: Washington

Subject: Universal Access for Essential Public Health Services

Referred to: Reference Committee D

Whereas, We have not gained a consensus on what are the essential public health services that everyone in our country is entitled to receive; and

Whereas, Various independent public health entities have developed their own proprietary list of "essential" and/or "foundational" public health services; and

Whereas, Public health governance structures and funding sources vary greatly by region, state, and jurisdiction across the country; and

Whereas, Compartmentalized, competitive, unpredictable, and inflexible funding leaves many health departments without financing for all essential public health services and necessary capabilities; and

Whereas, A lack of coordination and information sharing between local jurisdictions, state departments of health, and federal entities reduces the effectiveness of interventions to manage nationwide public health problems, including outbreaks; and

Whereas, We have no means to accurately capture capabilities and spending on essential public health services in every jurisdiction in order to determine if there is a current lack of universal access; and

Whereas, We have no means of collecting outcomes data in order to monitor the access to and cost effectiveness of our public health interventions; therefore be it

RESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:

1. a list of all essential public health services that should be provided in every jurisdiction of the United States;
2. a nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;
3. a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and
4. a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further

RESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/06/21

AUTHOR'S STATEMENT OF PRIORITY

Every American has a right to universal access to all essential public health services, yet evidence suggests a nationwide lack of meaningful access. Our public health system has clearly failed. Why? Because it is fragmented, endured a decade of excessive budget and job cuts, struggles with archaic information systems, and a complete lack of nationwide leadership.

These deficiencies were painfully exposed last year when hundreds of thousands of Americans needlessly died during a pandemic. We saw that our federal government was unable to take an evidence based, leadership role in a coordinated response. Too many decisions were left to states. Our public health capabilities were grossly deficient. And we learned that serious harm occurs when science and public health expertise are stifled by political interference and misinformation.

It is time for our AMA to study our current public health infrastructure in order to better define the existing problems so we can consider possible solutions.

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RELEVANT AMA POLICY

Federal Block Grants and Public Health H-440.912
(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.
Citation: CSA Rep. 3, A-96; Reaffirmation A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 424, A-11; Appended: Res. 935, I-11; Reaffirmation A-15; Reaffirmed in lieu of: Res. 419, A-19

Universal Access for Essential Public Health Services D-440.924
Our AMA: (1) supports updating The Core Public Health Functions Steering Committee's "The 10 Essential Public Health Services" to bring them in line with current and future public health practice; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State

and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system.
Citation: Res. 419, A-19

Support for Public Health D-440.997
1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.
2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.
3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.
Citation: Res. 409, A-99; Modified CLRPD Rep. 1, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 206, A-13; Reaffirmation A-15; Appended: Res. 902, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(JUN-21)

Introduced by: Oklahoma

Subject: Modernization and Standardization of Public Health Surveillance Systems

Referred to: Reference Committee D

Whereas, Epidemiologic data collection is paramount to targeting and implementing evidence-based control measures to protect the public's health and safety; and

Whereas, Accurate data collection is essential for anticipation of, preparation for, and response to a public health crisis; and

Whereas, Combining data from various sources, identifying the most relevant data for meaningful results, and standardizing collection and reporting to enable actionable analysis are chronic challenges--not the lack of data; and

Whereas, Technologies and surveillance systems play an integral, increasing, and evolving role in supporting public health responses to outbreaks or other urgent public health events; and

Whereas, Responding to urgent public health issues expeditiously requires balancing the speed of response with the need for accurate data and information to support the implementation of control measures; and

Whereas, The analyses and results are only as good as the quality of the data collected; and

Whereas, The COVID-19 pandemic demonstrated significant discrepancies in how data was collected, reported, analyzed, and ultimately acted upon at local, state and federal levels of government; and

Whereas, Standardization of data collection and data fields including local, state and federal should help with such discrepancies; therefore be it

RESOLVED, That our American Medical Association advocate for the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments, including but not limited to increased federal coordination and funding. (Directive to Take Action)

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

Received: 05/05/21

AUTHORS STATEMENT OF PRIORITY

As COVID-19 pandemic has demonstrated, the United States is woefully ill-equipped to anticipate, prepare, and respond concertedly to the threat of wide-spread disease. Epidemiologic data collection is foundational to public health services and is an essential tool in targeting and implementing evidence-based control measures to protect the public's health and safety. Yet, COVID-19 revealed the significant discrepancies in how data is collected, reported, analyzed, and ultimately acted upon at local, state and federal levels of government. The challenge is not the lack of data but rather the identification of the most relevant data, the culling of said data from various sources that might not be standardized or interoperable, and its appropriate analysis to enable meaningful and actionable results. Today's advanced informatic knowledge allows for no excuse for this failure.

This top priority resolution asks our AMA to advocate for an investment to modernize and standardize the public health surveillance systems, reaching from the federal to state and local governments. This effort will foster the vital coordination of entities such as the FDA, CDC, and US Department of Homeland Security to guide and protect the health of our nation.

AMA espouses a primary goal of promoting the betterment of public health. Voting to pass this resolution to be heard by the AMA House of Delegates is an act of such an espousal. Important action is needed now to not only prevent further harm, but to empower our physicians to better care for their patients and the communities in which they live.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(JUN-21)

Introduced by: New Jersey

Subject: Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America

Referred to: Reference Committee D

Whereas, Excess adipose tissue, an active endocrine organ, more commonly referred to as obesity has been a key contributor to poor health and to the most common complications such as cardiovascular disease associated with higher risks of death during pregnancy; and [1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16]

Whereas, The COVID-19 pandemic has further led the CDC to recognize obesity as the 2nd most significant risks factor for severe COVID infection and death from COVID -19; and [17]

Whereas, The cost of care attributable to obesity has been estimated in 2016 at > 1.72 trillion dollars (9.3% of GDP per year) while the cost saving of weight loss has been measured and is substantial; and [25,26]

Whereas, Despite years of advocacy already undertaken by our AMA and other medical organizations, the prevalence of obesity has consistently increased, now affecting nearly 200 million lives in the US, and has contributed to killing an estimated 320,000 Americans per year; and [23,24]

Whereas, Effective evidence-based interventions such as intensive lifestyle modifications, pharmacotherapy, and surgery to prevent and treat obesity exist, and such interventions have been shown to be associated with improved health and pregnancy outcomes and reduced health care costs; and [6,27,28,29,30,31,32,33,34,35,36,37,38,39,40]

Whereas, Significant barriers to providing care to patients, particularly within minority communities where 54% of Black and 50% of Hispanic women in comparison to 38% of white women are affected by obesity remain;[. 23 24,41,42,43] and

Whereas, The 1933 White House Conference on Maternal Mortality and Child Health protection, which led to a call for action by state medical association and resulted in a 100-fold decrease in maternal mortality, is recognized as one of the greatest healthcare accomplishments of the 20th century and provides precedent; therefore be it [18]

RESOLVED, That our American Medical Association advocate for a National Task Force to be led by the medical profession along with other stakeholders to confront the epidemic of obesity primarily among minority women, prior to, during and after pregnancy, thereby reducing maternal mortality & morbidity rates, racial disparity in access to care, death from COVID-19 infection and healthcare costs while restoring health in our nation with report back at the 2021 Interim Meeting and beyond. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/10/21

AUTHOR'S STATEMENT OF PRIORITY

Statement of Urgency and Need for National Call for Action.

Obesity has long been recognized as a key contributor to poor health, as well as to the various medical and surgical complications associated with higher risk of Maternal Mortality and Morbidity. [1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16]

Obesity was also recognized more recently by the CDC as 2nd only to age as a major risk factor for severe COVID infection and death. [17]

Despite all of its resources, the United States has the highest maternal mortality rate among developed countries, the disparity in rates for minority women are 4 - 5.2 times higher than for white and even higher in certain places.[18,19,20,21,22,23,24]

The incomprehensible loss of lives during the COVID-19 pandemic has been exacerbated by the epidemic of obesity .[17] Obesity related healthcare cost in 2016 was estimated at over 1.7 trillion dollars.[25]Cost savings from weight reduction are expected to be substantial.[26]

Reducing obesity would have a significant impact on deaths from COVID-19 as well as on maternal mortality. With obesity prevalence historically highest among minority women now affecting > 50% of minority women the contribution of obesity to maternal mortality and morbidity and death from Covid-19 can no longer be ignored.[17,18,23,24,25]

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(JUN-21)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Support for Safe and Equitable Access to Voting

Referred to: Reference Committee D

Whereas, Universal vote-by-mail, also known as voting absentee, allows eligible citizens and residents to vote by mail[1]; and

Whereas, Sixteen states require eligible voters to declare a reason in order to request a ballot by mail, and at least five (Indiana, Louisiana, Mississippi, Tennessee, and Texas) do not accept risk or fear of COVID-19 infection as a valid reason[2-4]; and

Whereas, COVID-19 is a novel, easily-transmissible viral respiratory disease that since January 2020 has been contracted by 6.7 million Americans and has been linked with the deaths of over 198,000[5-6]; and

Whereas, Risk factors for severe COVID-19 disease are common in the US, such as smoking, with a prevalence of 14% of adults in 2018[7]; obesity, with a prevalence of 42% of adults in 2017-2018[8]; and diabetes with a prevalence of 10% of adults in 2018[9]; and

Whereas, Public health experts continue to warn governments and the public to prepare for future pandemics which may arise similarly to the COVID-19 pandemic[10-12]; and

Whereas, A study of the 2020 Wisconsin primaries found “a statistically and economically significant association between in-person voting and the spread of COVID-19 two to three weeks after the election”[13]; and

Whereas, The COVID-19 pandemic is likely to be playing a role in voter suppression, with reductions in new voter registrations by as much as 70% due to Department of Motor Vehicle closures, limited in-person interactions, and the cancellation of many large public gatherings[14]; and

Whereas, Many previous poll workers declined to serve in the 2020 primary elections due to fear of contracting severe COVID-19, and ultimately there were far fewer polling locations and longer waiting times in the 2020 primaries[15-17]; and

Whereas, Following widespread adoption of community mitigation measures to target SARS-CoV-2, influenza rates among sentinel countries in the southern hemisphere have been dramatically lower than historical averages during their peak influenza season[18], suggesting the continuance of such measures past the COVID-19 pandemic could contribute to a reduction in the incidence of influenza; and

Whereas, 1 in 4 American adults, and 2 in 5 adults over the age of 65 live with a disability[19]; and

Whereas, In the 2016 general election, the US Government Accountability Office found that 60% of the polling places evaluated were inaccessible to voters with disabilities, resulting in unsafe or insecure conditions for these voters[20]; and

Whereas, Voters with disabilities are more likely to vote by mail, and implementing no-excuse absentee balloting and permanent absentee voting increases voter turnout among citizens with disabilities[21]; and

Whereas, A 2013 survey found 2.7% of Americans self-report as immunosuppressed, a figure that likely has increased in the years since given greater life expectancy among immunosuppressed adults due to advancements in medical management and new indications for immunosuppressive treatments[22]; and

Whereas, Universal vote-by-mail does not favor either major party's voter turnout or vote share[23]; and

Whereas, Vote-by-mail is already a commonly-used option amongst voters, with approximately 23.1% of all votes cast in the 2018 general election having been by mail[24]; and

Whereas, Members of the military have voted-by-mail in some form since the Civil War, and citizens living abroad also submit their ballots by mail[25-27]; and

Whereas, Universal vote-by-mail does not depress voter turnout, but rather moderately increases overall average turnout rates, in line with previous estimates[23]; and

Whereas, Numerous national and local government officials have expressed opposition to expanding eligibility to vote-by-mail despite the ongoing risk of COVID-19 infection[24,28-32]; and

Whereas, There is no demonstrated increased risk of election fraud via vote-by-mail, with one study finding only 0.0025% of votes being flagged as possible cases of election fraud in the 2016 and 2018 general elections[33]; and

Whereas, Our AMA recognized the severity of the COVID-19 pandemic, and chose to cancel the in-person proceedings of the 2020 Interim Meeting while preserving the voting process through transition to an innovative virtual format[34]; and

Whereas, While the 2020 General Election ends on November 03, COVID-19 exposure will continue to be an urgent risk for voters and poll workers in subsequent elections like federal runoff elections conducted in Georgia and Louisiana and local elections conducted in Spring 2021[35-38]; therefore be it

RESOLVED, That our American Medical Association support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to:

(a) extending polling hours;
(b) increasing the number of polling locations;
(c) extending early voting periods;
(d) mail-in ballot postage that is free or prepaid by the government;
(e) adequate resourcing of the United States Postal Service and election operational procedures;
(f) improve access to drop off locations for mail-in or early ballots (New HOD Policy); and be it further

RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

The AMA missed an opportunity to have a more significant voice during the last special election and continues to be left out of the important discussion regarding voting as a right and its contribution to the social determinants of health. Discussion of this resolution is timely for state and local election and if we will be prepared for 2022, we must pass this now to give our staff time to strategize. The asks are appropriately narrow, pertinent, and relevant to the large majority of our patients and colleagues.

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RELEVANT AMA POLICY

H-440.892 Bolstering Public Health Preparedness

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved

areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.
Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19.

H-65.971 Mental Illness and the Right to Vote
Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.
Res. 202, A-10; Reaffirmed: BOT Rep. 04, A-20.

H-295.953 Medical Student, Resident and Fellow Legislative Awareness
1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.
Res. 14, A-91; Reaffirmed: Sunset Report, I-01; Appended: Res. 317, A-10; Appended: Res. 307, A-15

G-615.103 Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy
Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; and (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.
Res. 608, A-17

H-285.910 The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:
Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of his/her rights under this paragraph.
Res. 8, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Traumatic Brain Injury and Access to Firearms

Referred to: Reference Committee D

Whereas, Traumatic brain injury (TBI) is a prevalent issue in society with approximately 1.7 million incidents annually, a third of which contribute to injury-related deaths in the US; and

Whereas, Although extensive research is conducted in the field to better assess interventions in limiting consecutive brain damage after the initial head trauma, the actual mechanisms of neural recovery are poorly understood; and

Whereas, An increased focus is placed on therapies to treat individuals who have sustained brain injury and to improve their long-term recovery as many of these individuals suffer from significant cognitive, behavioral, and communicative disabilities which interfere with their daily activities and lives; and

Whereas, Approximately 20% of patients develop long-term medical complications such as epilepsy, Alzheimer's disease, Parkinson's syndrome, and depression in addition to their initial medical treatments after sustaining injury which costs the nation's healthcare more than $56 billion each year; and

Whereas, There are some very important policies that the AMA has supported that relate to gun violence and injury prevention. In H-145-997, the AMA acknowledges that firearms are a public health problem, encourages research into innovative manufacturing techniques, advocates for additional funding toward developing new safer weapon designs, and promotes education programs for firearm safety and prevention; and

Whereas, Our AMA has since developed several other corollary policies surrounding firearm violence prevention and intervention. Some of these policies asked for the establishment of preventative measures which would target the sale and manufacture of guns, specifically to decrease the availability. AMA policies calling for a waiting period preceding any firearm purchase include H-145.991, H-145.992, and H-145.996. Policies calling for the imposition of background checks for handgun purchases include H-145.991, H-145.996, H-145.970, and H 145.972; and

Whereas, TBI is a wide-ranging diagnosis that encompasses a variety of phenotypes and amending current policy would be more effective if intentionally defines TBI and high-risk individuals; and

Whereas, Our AMA has policy supporting screening by physicians for a number of public health and health concerns, including, not limited to: intimate partner and family violence (D-515.980, H- 515.981), potential violent behavior within mental health assessments (H-145.975), alcohol and drug use (H-30.942, H-95.922), pediatric mental health screening

(H-345.977), social and economic risk factors (H-160.896), maternal depression (D-420.991), and adverse childhood events (H-515.952); and

Whereas, While our AMA has policy regarding sports-related injuries and concussions, which includes TBI, there is not any policy that involves the importance of screening for active symptoms or history of TBI in settings such as primary care, pediatrics, psychiatry, neurology, schools, homeless shelters, within the criminal justice system, and athletic communities; and

Whereas, Failing to identify TBI may have severe consequences. Screening tools like the Ohio State University TBI-ID Method (OSU-TBI-ID), Brain Injury Screening Questionnaire (BISQ), HELPS Brain Injury Screening Tool, and Brain Check Survey may aid in the identification of those at risk for more severe consequences, and allow for supportive measures such as vocational rehabilitation or cognitive rehabilitation; therefore be it

RESOLVED, That our American Medical Association reaffirm policy H-145.972 “Firearms and High-Risk Individuals” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-145.975 “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care” by addition and deletion to read as follows:

…2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental ~~illness~~ health and ~~concurrent~~ substance use disorders~~.~~ in patients with traumatic brain injuries, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.

~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Modify Current HOD Policy)

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

Received: 05/10/21

The topic of this resolution is currently under study by the Council on Science and Public Health.

AUTHOR’S STATEMENT OR PRIORITY

This policy will update current AMA policies to better address the burden traumatic brain injuries place on patients and ensure appropriate access to dangerous weapons.

RELEVANT AMA POLICY

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Citation: Sub. Res. 221, A-13Appended: Res. 416, A-14Reaffirmed: Res. 426, A-16Reaffirmed: BOT Rep. 28, A-18Reaffirmation: A-18Modified: CSAPH Rep. 04, A-18Reaffirmation: I-18

Screening and Brief Interventions For Alcohol Problems H-30.942
Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.
Citation: CSA Rep. 14, I-99Reaffirmation I-01Modified: CSAPH Rep. 1, A-11Reaffirmation: A-18

Substance Use and Substance Use Disorders H-95.922
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
Citation: CSAPH Rep. 01, A-18Reaffirmed: BOT Rep. 14, I-20

Violence Prevention H-145.970
Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.
Citation: BOT Rep. 11, I-18

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
Citation: CSAPH Rep. 04, A-18Reaffirmed: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
Citation: Sub. Res. 221, A-13Appended: Res. 416, A-14Reaffirmed: Res. 426, A-16Reaffirmed: BOT Rep. 28, A-18Reaffirmation: A-18Modified: CSAPH Rep. 04, A-18Reaffirmation: I-18

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
Citation: Res. 414, A-11Appended: BOT Rep. 12, A-14Reaffirmed: Res. 403, A-18

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
Citation: BOT Rep. 39, A-18Reaffirmed: CMS Rep. 10, A-19

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
c. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
e. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma at any time in life.
Citation: Res. 504, A-19

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.
Citation: Res. 903, I-17Modified: CSAPH Rep. 01, I-18

Family Violence-Adolescents as Victims and Perpetrators H-515.981
The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.
Citation: CSA Rep. I, A-92Reaffirmed: CSA Rep. 8, A-03Modified: CSAPH Rep. 1, A-13

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991
Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.
Citation: Res. 910, I-17

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.
Citation: Sub. Res. 34, I-89Reaffirmed: BOT Rep. 8, I-93Reaffirmed: BOT Rep. 50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Modified: Res. 401, A-17Reaffirmation: A-18Reaffirmation: I-18

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.
Citation: Res. 171, A-89Reaffirmed: BOT Rep.50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17Reaffirmation: A-18

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87Reaffirmed: BOT Rep. 8, I-93Reaffirmed: BOT Rep. 50, I-93Reaffirmed: CSA Rep. 8, A-05Reaffirmed: CSAPH Rep. 1, A-15Modified: BOT Rep. 12, A-16Appended: Res. 433, A-18Reaffirmation: I-18Modified: BOT Rep. 11, I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
Citation: CSA Rep. A, I-87Reaffirmed: BOT Rep. I-93-50Appended: Res. 403, I-99Reaffirmation A-07Reaffirmation A-13Appended: Res. 921, I-13Reaffirmed: CSAPH Rep. 04, A-18Reaffirmation: A-18Reaffirmation: I-18Appended: Res. 405, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(JUN-21)

Introduced by: District of Columbia, American College of Cardiology, Obesity Medicine Association, American Association of Clinical Endocrinologists

Subject: Attacking Disparities in COVID-19 Underlying Health Conditions

Referred to: Reference Committee D

Whereas, COVID-19 mortality is much higher in individuals with obesity, diabetes, and hypertension, compared with those who do not have these conditions; and

Whereas, These health conditions can be rapidly improved with appropriate medical treatment; and

Whereas, The disproportionate impact of these chronic conditions in communities of color contribute to disparities in COVID-19 mortality; and

Whereas, Medical treatment can be optimized when, as part of medical care, patients also begin healthful lifestyle interventions, such as physical activity and reduced-sodium or plant-based diets, which are already part of our AMA's policies for health care facilities (H-150.949), public schools, food markets, restaurants (H-150.922), food assistance programs (H-150.944), and federal health policy (D-440.978), but have been neglected during the Covid-19 pandemic, causing overall health to decline and vulnerability to increase; and

Whereas, Existing AMA policy on obesity does not yet include the urgency, specificity, or call to action required by the current pandemic and does not cover other underlying conditions; and

Whereas, While media attention has focused on reducing coronavirus transmission through personal hygiene, masks, social distancing, and vaccinations, there has been insufficient attention to the urgent need to control the underlying medical conditions that make COVID-19 especially deadly; therefore be it

RESOLVED, That our American Medical Association urge federal, state, and municipal leaders to prominently note in their COVID-19 public health advisories the urgent need for individuals with underlying medical conditions, particularly obesity, type 2 diabetes, and hypertension, to consult with their physicians to assess their medical status and institute (or resume) appropriate treatment, which may range from updating medications and lifestyle changes, such as reduced-sodium and plant-based diets and physical activity, to aggressive medical therapy which may include medication, surgery, and complex multi-disciplinary care. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

As of November 17, the final day of our interim meeting, 251,094 Americans had died from Covid-19. Between that date and April 20, 2021, Covid-19 killed an additional 304,868 Americans. Another 60,000 deaths are expected before August. While vaccines are essential for reducing mortality, the vaccination process is incomplete, and new viral variants make long-term vaccination efficacy uncertain. It is urgent that we protect our patients by addressing the underlying health conditions driving Covid-19 mortality. This resolution was introduced at the interim meeting but was deferred to the present meeting due to time constraints.

Covid-19 mortality is ten-fold higher when patients' diabetes is in poor control than when it is under good control. Similarly, poorly controlled hypertension increases Covid-19 mortality. With medical care, blood glucose and blood pressure control can be achieved within days. According to recent modeling, 30 percent of hospitalizations for COVID-19 are attributable to obesity, and although resolution of body weight is more challenging that blood pressure or blood sugar control, physicians play a vital role in this process.

Many patients have neglected their medical care during the pandemic and have allowed these chronic diseases to deteriorate. Local authorities are doing little to emphasize the urgency of controlling the underlying conditions that make Covid-19 a killer.

RELEVANT AMA POLICY

Healthful Food Options in Health Care Facilities H-150.949
1. Our AMA encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of Health Care Facilities.
2. Our AMA hereby calls on all Health Care Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for Health Care Facility cafeterias and inpatient meal menus to publish nutrition information.
Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18; Modified: Res. 904, I-19

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.
Citation: Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Culturally Responsive Dietary and Nutritional Guidelines D-440.978
1. Our AMA and its Minority Affairs Section will: (a) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (b) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (c) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (d) monitor existing research and identify opportunities where organized medicine can impact issues related to

obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.
2.Our AMA will: (a) propose legislation that modifies the National School Lunch Act, 42 U.S.C. 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cows milk; and (b) recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, based on an individuals dietary needs.
Citation: BOT Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14; Modified: Res. 203, A-18;

Reduction in Consumption of Processed Meats H-150.922
Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.
Citation: Res. 406, A-19

Recognition of Obesity as a Disease H-440.842
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
Citation: (Res. 420, A-13)

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
Citation: CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19

Addressing Obesity D-440.954
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3.Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18;

Obesity as a Major Health Concern H-440.902
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.
Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
Citation: Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07; Appended: Sub. Res. 315, A-15; Modified: CME Rep. 03, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(JUN-21)

Introduced by: Oregon

Subject: Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities

Referred to: Reference Committee D

Whereas, Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care; and

Whereas, The Covid-19 pandemic has exposed gaps in our ability to safely staff long-term healthcare facilities (LTC) due to rapid escalation in numbers of affected residents combined with reduced numbers of staff available for their care; and

Whereas, Many complex factors contribute to reduced HCP availability in a pandemic situation or other times of crisis including but not limited to: illness among healthcare personnel; social factors such as transportation, housing, childcare and care of other family members; widespread demand for HCP which creates a local deficit in staff availability and competition for workers' scheduled time especially when HCP work at multiple facilities; quarantine requirements for HCP who have had a suspected or known exposure; and

Whereas, The existing LTC workforce is disproportionately composed of racial and ethnic minorities who are at risk for worse outcomes should they develop COVID-19 and they may also be in high risk categories for other reasons or have family members in high risk categories, reducing their willingness to assume the increased rick of caring for patients with highly contagious illnesses; and

Whereas, The narrow revenue margin for companies managing LTC facilities dictates lean staffing ratios in order to keep the business viable; and

Whereas, All these factors result in few options for mitigations of staffing challenges in LTC facilities in a crisis, worsening the safety of HCP in the work environment and placing residents/patients at risk of unsafe care environments when staff availability is reduced; and

Whereas, A safe and adequately resourced work environment is an issue of justice, equity, and respect for both LTC workers and the vulnerable elderly population in our country; therefore be it

RESOLVED, That our American Medical Association study the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

a) Planning for adequate funding and access to resources;
b) Planning for emergency staffing of health care and maintenance personnel;
c) Planning for ensuring safe working conditions of LTC staff; and
d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Oregon delegation considers this a Medium Priority Resolution. The SARS-CoV-2 (Covid-19) pandemic highlighted the exceptional healthcare provider (HCP) staffing challenges experienced in long-term care (LTC) facilities. Covid 19 has disproportionately impacted older adults and residents of long-term care facilities. Additionally, LTC facilities are also disproportionately composed of racial and ethnic minorities who are risk for worse outcomes should they develop Covid-19. In a pandemic such as Covid-19, current LTC staffing models, coupled with the greater impact Covid-19 has had on LTC residents, has left few options for mitigating staffing challenges. Additionally, HCP working in LTC facilities experience higher risk for contracting Covid-19, further jeopardizing staffing availability and increasing risk to residents/patients.

The American Medical Association (AMA) should study and collaborate to make policy to guide federal, state and local public health to ensure safe operation of LTC facilities during public health emergencies, including natural disasters. This resolution directly affects physicians who work in LTC facilities or closely with those facilities, but it also affects larger systems of care who may utilize providers from other locations to help mitigate staffing challenges during a public health emergency.

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covid-19-in-long-term-care-facilities/ (April 23, 2020)
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(JUN-21)

Introduced by: Pennsylvania

Subject: Screening for HPV-Related Anal Cancer

Referred to: Reference Committee D

Whereas, 8,300 adults in the US will be diagnosed with anal cancer with an estimated 1,280 deaths in 2019[1]; and

Whereas, The human papillomavirus (HPV) causes more than 90% of anal cancers[2] and HPV testing can be conducted via screening anal Pap test and/or HPV test; and

Whereas, Studies have identified the value of anal cancer screening for high-risk populations since AMA policy was adopted to support continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer[3]; and

Whereas, The American Society for Colon and Rectal Surgeons (ASCRS) has developed a strong recommendation based on moderate quality evidence, 1B, stating that patients at increased risk for anal squamous neoplasms should be identified by history, physical examination and laboratory testing, noting that the risk is higher in HIV-positive individuals, men who have sex with men (MSM), and women with a history of cervical dysplasia[4]; and

Whereas, The American Cancer Society reports expert opinion that (1) anal pap smear testing is a reasonable approach for screening patients at increased risk by swabbing the anal lining for microscopic analysis; (2) although there is no widespread agreement on the best screening schedule, some experts recommend the test be done every year in MSM or HIV-positive individuals and every 2-3 years in the HIV-negative population; (3) patients with positive results on an anal pap test should be referred for a biopsy; and (4) if anal intraepithelial neoplasia is found on the biopsy, it might need to be treated especially if it is high grade[5]; and

Whereas, An expert panel convened by the American Society for Colposcopy and Cervical Pathology and the International Anal Neoplasia Society suggests that HIV-positive women and women with lower genital tract neoplasia may be considered for screening with anal cytology and triage to treatment if anal high-grade squamous intraepithelial lesions (HSIL) is diagnosed[6]; and

Whereas, Dacron swab cytology provides modest sensitivity and nylon-flocked swab cytology has higher specificity and accuracy for detecting high grade squamous intraepithelial lesion in anal cancer and has been proposed to lower costs of population-based screening[7]; and

Whereas, Preliminary analyses have shown anal cancer screening to be cost effective for HIV-positive individuals, MSM, and women with a history of cervical dysplasia with quality life adjusted years (QALYs) increases of 4.4 years at a cost of $34,763 per life year gained overall, and particular cost effectiveness of annual anal pap testing for MSM at a cost of $16,000 per QALY saved[8]; therefore be it

RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations (New HOD Policy); and be it further

RESOLVED, That our AMA support national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

National Cancer Institute. SEER anal cancer stat facts
2021 https://seer.cancer.gov/statfacts/html/anus.html.
Estimated New Cases in 2021 9,090
% of All New Cancer Cases 0.5%
Estimated Deaths in 2021 1,430
% of All Cancer Deaths 0.2%

The low prevalence of anal cancer in the general population prevents the use of routine screening. However, screening of selected populations has been shown to be a more promising strategy. Potential screening modalities include digital anorectal exam, anal Papanicolaou testing, human papilloma virus co-testing, and high-resolution anoscopy. Expands current policy to include up to date techniques.

Current AMA Policy

- Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913
- Our AMA supports continued research on the diagnosis and treatment of **anal cancer** and its precursor lesions, including the evaluation of the **anal** pap smear as a **screening** tool for **anal cancer**.

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1. Cancer Facts & Figures 2019
2. About HPV / HPV & Cancer. https://www.analcancerfoundation.org/about-hpv/hpv-cancer/
3. Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia H-460.913
4. Stewart, DB, et al. The American Society of Colon and Rectal Surgeons Clinical Practice Guidelines for Anal Squamous Cell Cancers: Dis of Colon & Rect. 2018 61(7): 755–774.
5. American Cancer Society Anal Screening: https://www.cancer.org/cancer/anal-cancer/detection-diagnosis-staging.html
6. Moscicki AB, et al. Screening for Anal Cancer in Women. Journal of Lower Genital Tract Disease. 2015 Jul; 19(3):S27-S42.
7. Wiley DJ, et al. Comparison of nylon-flocked swab and Dacron swab cytology for anal HSIL detection in transgender women and gay, bisexual, and other men who have sex with men. Cancer Cytopathol. 2019 Apr; 127(4):247-257.
8. Wells J, et al. An integrative review of guidelines for anal cancer screening in HIV-infected persons. AIDS Patient Care STDS. 2014 Jul;28(7):350-7.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(JUN-21)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Weapons in Correctional Healthcare Settings

Referred to: Reference Committee D

Whereas, The required carrying of rapid rotation baton by all law enforcement officers is being introduced into some Mental Health Units in federal correctional facilities in 2021; and

Whereas, Physicians in federal correctional healthcare settings who are employed by the Federal Bureau of Prisons are considered law enforcement officers; and

Whereas, Weapons are here defined in the CMS State Operations Manual: CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals Section 482.13(e) as "includes, but is not limited to, pepper spray, mace, nightsticks, tazers [sic], cattle prods, stun guns, and pistols." (CMS, 2020); and

Whereas, Eighty percent of violent incidents in hospitals are by patients towards staff. Incidents of serious workplace violence (requiring days off work) are four times more common in healthcare settings than in private industry, so an intentional plan and response to reduce workplace violence is indicated (OSHA, 2015); and

Whereas, The American Psychiatric Association does not support the use of weapons as a clinical response in the management of patient behavioral dyscontrol in emergency room and inpatient settings because such use conflicts with the therapeutic mission of hospitals (APA, 2018); and

Whereas, Patients who pose a risk of harm to others should be managed by clinical staff using clinical approaches. These clinical approaches will typically involve psychological interpersonal interventions and when less restrictive alternatives fail, the use of involuntary emergency medication, physical seclusion, and physical or mechanical restraint, following guidelines issued by The Joint Commission and CMS. (APA, 2018, Allen et al, 2005); and

Whereas, The National Commission on Correctional Health Care supports the active prevention of violence through nonphysical methods to prevent and/or control disruptive behaviors including a balanced biopsychosocial approach (NCCHC, 2013); and

Whereas, Our *AMA Code of Ethics* notes “Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm” (AMA Code of Ethics Opinion 9.7.2); and

Whereas, Our *AMA Code of Ethics* notes “Individual physicians who provide care under court order should: Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.”

(AMA Code of Ethics Opinion 9.7.2); and

Whereas, Our *AMA Code of Ethics* notes “Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely” (AMA Code of Ethics Opinion 1.1.7); and

Whereas, The presence of weapons from any source is likely to increase safety concerns without added safety for patients or staff; and

Whereas, The presence of weapons within any healthcare facility may erode the physician-patient relationship, limit access to care, and increase the vulnerability of those individuals and communities who have experienced systemic racism and violence from law enforcement officers (Liebschutz et al., 2010); and

Whereas, The presence of weapons within correctional healthcare facilities may trigger aggression and agitation worsening behavioral dysregulation via the weapons effect (Berkowitz and Le Page, 1967); therefore be it

RESOLVED, That our American Medical Association advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care (Directive to Take Action); and be it further

RESOLVED, That our AMA study and make recommendations regarding the presence of weapons in correctional healthcare facilities. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

COVID-19 shone a bright light on the vulnerabilities with our healthcare systems and long-standing health disparities. Concurrently, the increased awareness of the police brutality experienced by Black individuals led the AMA to call racism a public health problem. Few areas of American life demonstrate the severity and urgency of both these public crises like the criminal justice system.

The U.S. has 5% of the world's population, yet 25% of the world's prisoners. Individuals within the criminal justice system have a higher burden of chronic physical/mental health disorders and a lower life expectancy. These individuals have a constitutional right to healthcare treatment. Yet, these facilities are underserved and under resourced.

Correctional facilities are the largest mental health institutions with 1 out of 5 individuals with serious mental health or substance use disorders. These people are more vulnerable and incarcerated longer than other prisoners. It is imperative that AMA's House of Delegates views issues related to healthcare treatment in these institutions as urgent business given the ongoing harms and the potential for even worse outcomes. AMA must advocate addressing the health safety of those designated to correctional facilities and their healthcare providers. This resolution asks AMA to provide care consistent with community treatment free of less lethal and lethal weapons in health care environments and second to advocate for physicians employed by federal correctional institutions to have maintain their individual right to decline to carry less lethal weapons in matter consistent with current policy where lethal weapons are not mandated.

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Allen MH, Currier GW, Carpenter D, Ross RW, Docherty JP; Expert Consensus Panel for Behavioral Emergencies 2005. The expert consensus guideline series. Treatment of behavioral emergencies 2005. J Psychiatr Pract. 2005 Nov;11 Suppl 1:5-108; quiz 110-2. PubMed PMID: 16319571. https://pubmed.ncbi.nlm.nih.gov/11500996/

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AMA Code of Ethics (2021) Code of Medical Ethics Opinion 1.1.7 Physician Exercise of Conscience Accessed 2/22/21 https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience

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OSHA (2015) Workplace Violence in Healthcare: Understanding the Challenge. U.S. Department of Labor Occupational Safety and Health Administration. OSHA 3826 - 12/2015 https://www.osha.gov/Publications/OSHA3826.pdf

RELEVANT AMA POLICY

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs
Citation: (CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)

Guns in Hospitals H-215.977
1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:
A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.
B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.
C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.
D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.
E. Policies should undergo periodic reassessment and evaluation.
F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.
2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present
Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Policing Reform H-65.954
Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.
Citation: Res. 410, I-20

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.
Citation: Res. 923, I-15; Appended: Res. 220, I-18

Preventing Violent Acts Against Health Care Providers D-515.983
Our AMA will (a) continue to work with other appropriate organizations to prevent acts of violence against health care providers and improve the safety and security of providers while engaged in caring for patients; and (b) widely disseminate information on effective workplace violence prevention interventions in the health care setting as well as opportunities for training.
Citation: Res. 437, A-08; Modified: CSAPH Rep. 2, I-10; Appended: Res. 607, A-15; Modified: CSAPH Rep. 07, A-16;

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(JUN-21)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Ensuring Adequate Health Care Resources to Address the Long COVID Crisis

Referred to: Reference Committee D

Whereas, Due to the COVID-19 pandemic, 3 to 10 million Americans are likely to experience Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID"); and

Whereas, According to recent publications 10-30% of individuals who had COVID-19 reported at least one persistent symptom up to six months after their infection was cleared[1,2]; and

Whereas, Individuals with PASC may experience varied and chronic symptoms including neurologic, cognitive, cardiopulmonary, constitutional, musculoskeletal, psychiatric, and mobility impairments; and

Whereas, Most patients impacted by PASC seek to regain their quality of life and return to being active members of their communities; and

Whereas, The current medical system in the United States lacks the necessary resources and infrastructure to adequately support and provide expert care to patients with PASC; and

Whereas, An application for an ICD-10-CM code for PASC has been submitted to the National Center for Health Statistics for review, but there is no current coding for PASC or organized reimbursement structure to support PASC multidisciplinary clinics nor are there dedicated resources to provide comprehensive care to PASC patients; and

Whereas, PASC patients need timely and local access to multidisciplinary care to address their complex needs including inequities inherent to our current health care system that result in disparate access associated with racial, ethnic, geographic, socioeconomic, and disability factors; and

Whereas, Ongoing and future PASC research results, that are inclusive of all populations, including people with disabilities and underlying health conditions, are needed in real-time to support providers through rapid development and widespread dissemination of best practices for PASC care; and

Whereas, Nearly 50 organizations including members of the federation have supported a letter urging the Biden Administration to launch a commission of diverse experts to develop a comprehensive federal crisis plan and prioritize actions to address the care needs of patients with PASC; therefore be it

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[1] Rubin R. As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts. JAMA. 2020; 324(14):1381–1383. doi:10.1001/jama.2020.17709

[2] Logue JK, et al "Sequelae in Adults at 6 Months After COVID-19 Infection" JAMA Netw Open 2021; DOI: 0.1001/jamanetworkopen.2021.0830.

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID") as a distinct diagnosis (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the development of immediate and long-term strategies for funding and research to address equitable access to appropriate clinical care for all individuals experiencing PASC (Directive to Take Action); and be it further

RESOLVED, That our AMA disseminate up-to-date information to physicians regarding best practices to mitigate the effects of PASC in a timely manner. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered at the June 2021 Special Meeting of the AMA HOD, as it aims to address the current and future impact of COVID-19, including treatment of the ongoing symptoms following an initial COVID-19 infection. As we are still amid the pandemic, we have yet to fully realize the long-term effects of the virus. As 3 to 10 million Americans are likely to experience Long COVID, this issue will likely affect all physicians and their patients. Specifically, the goals of this resolution will ensure that patients who present with long COVID symptoms will have timely and local access to multidisciplinary care to address the broad and varying PASC symptoms. Time is of the essence for establishing a national strategy to address the Long COVID crisis. As the AMA and many other specialties have prioritized addressing the COVID-19 pandemic, having support from the full house of medicine will underscore this vital advocacy effort and will ensure PASC patients receive the care that is needed to reduce the long-term impacts of COVID-19.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(JUN-21)

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

Subject: Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens

Referred to: Reference Committee D

Whereas, Respiratory pathogens are a known cause of significant yearly morbidity and mortality worldwide; and

Whereas, It has long been known that the wearing of a mask by those with respiratory infection can reduce the expulsion of infected droplets and reduce transmission of infection; and

Whereas, Recent studies in light of COVID-19 of wearing masks by people who are not infected have shown a reduction in the acquisition of the coronavirus;[1,2,3,4] and

Whereas, The measures in place to reduce COVID-19, including use of masks by both the sick and the well, has been associated with unprecedented reductions in influenza and respiratory disease caused by other common viruses;[5] and

Whereas, The risk of pathogens, which are transmitted via respiratory droplets or aerosols, is an ongoing concern for morbidity and mortality even after the pandemic;[6,7,8] therefore be it

RESOLVED, That our American Medical Association endorse the use of masks for all those wishing to reduce the risk of respiratory tract infection during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors (Directive to Take Action); and be it further

RESOLVED, That our AMA promulgate scientific information to both patients and physicians about the benefits of masks to protect patients, especially those at high risk, to reduce exposure to and spread of respiratory pathogens. (Directive to Take Action)

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Fiscal Note: Not yet determined

Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

In spite of the fact there is an improvement in the spread of Covid, we face approximately 30,000 new cases daily in the US. Tragically worldwide there are extensive surges of Covid in South Asia and South America killing thousands daily.

The simplest evidence based public health measure to ameliorate the spread is to wear a mask. The AMA at the current meeting should endorse this resolution since there is currently extensive spread both domestically and internationally.

Just as important we should have this policy in place prior to the next flu season which will not happen if the resolution is delayed. Thank you in advance for your consideration of the urgency of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(JUN-21)

Introduced by: Women Physicians Section

Subject: Addressing Maternal Discrimination and Support for Flexible Family Leave

Referred to: Reference Committee D

Whereas, Findings from a study by Adesoye, Mangurian, Choo et al. on physician mothers and their experiences with workplace discrimination indicated that 77.9% of the respondents experienced some form of discrimination;[1] and

Whereas, Of these respondents, 66.3% of physician mothers reported experiencing gender discrimination and 35.8% reported experiencing maternal discrimination, which is defined as self-reported discrimination based on pregnancy, maternity leave, or breastfeeding;[1] and

Whereas, Employment laws, such as the Pregnancy Discrimination Act and the Title VII of the Civil Rights Act of 1964, protects individuals from discrimination based on protected class such as, sex, gender and pregnancy;[2] and

Whereas, The Fair Labor Standards Act includes some breastfeeding protections and requirements for maternity leave but no protections for any additional leaves dealing with parenting needs ;[3] and

Whereas, The Families First Coronavirus Response Act (FFCRA or Act) provides employees of covered employers two weeks of paid sick leave at the employee's regular rate or two-thirds the employee's regular rate of pay and up to an additional ten weeks of paid expanded family and medical leave at two-third of the employee's regular rate;[5] and

Whereas, The FFCRA does not provide coverage protections for physicians and other frontline workers as it specifically excludes health care providers and emergency responders;[5] and

Whereas, Maternal discrimination was associated with higher self-reported burnout (45.9% in physicians experiencing maternal discrimination compared to 33.9% burnout in those not experiencing maternal discrimination) even prior to the pandemic;[1] and

Whereas, Findings from a study by Templeton, Bernstein, Sukhera, et al. noted that women who are employed full time spend an additional 8.5 hours per week on childcare and other domestic activities which was before the demands of virtual schooling and homeschooling;[4] and

Whereas, Homeschooling rates have more than tripled during the pandemic due to educational needs and health concerns;[6] and

Whereas, Across the country almost two-thirds of parents say their children have switched to online learning which requires adult supervision;[7] and

Whereas, Mothers of young children have lost four to five times as many work hours compared to fathers in the pandemic due to women taking on the majority of childcare responsibilities;[7] and

Whereas, Male physicians are increasingly expressing interest in flexible family leave and work options, yet female physicians continue to bear primary responsibility for caregiving and may face more challenges in aligning their career goals with family needs; and

Whereas, Conflicts between work and life responsibilities, which have been exacerbated due to the pandemic, can have adverse consequences for women physicians, leading to further discrimination; and

Whereas, AMA Policy H-405.954, "Parental Leave," supports the establishment and expansion of paid parental leave; calls for improved social and economic support for paid family leave to care for newborns, infants and young children; and advocates for federal tax incentives to support early child care and unpaid child care by extended family members; therefore be it

RESOLVED, That our American Medical Association encourage key stakeholders to implement policies and programs that help protect against maternal discrimination and promote work-life integration for physician parents, which should encompass prenatal care, parental leave, and flexibility for childcare (Directive to Take Action); and be it further

RESOLVED, That our AMA urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The COVID-19 pandemic has had a regressive effect on gender equity, especially on women physicians who bear the burden of childcare in the household. The lack of services, such as education or childcare, has resulted in physicians with childcare responsibilities leaving the labor market. According to McKinsey Consulting, women's jobs are 1.8 times more vulnerable than men. Given the gender regressive pandemic scenario we are in, it is critical to take action now to advance gender parity. This resolution asks our AMA to urge key stakeholders to include physicians and frontline workers in the Families First Coronavirus Response Act as well as other legislation that provide protections and considerations for paid parental leave for issues of health and childcare.

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board

eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.
Citation: (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(JUN-21)

Introduced by: Medical Student Section

Subject: Call for Increased Funding and Research for Post Viral Syndromes

Referred to: Reference Committee D

Whereas, Post viral syndrome, also known as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), is frequently understood to be “overwhelming fatigue that is not improved by rest, and worsens after physical, mental, or emotional exertion”[1,2]; and

Whereas, The Institute of Medicine (IOM) developed diagnostic criteria for ME/CFS which require profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, orthostatic intolerance, and other symptoms[3]; and

Whereas, ME/CFS can be diagnosed through two consecutive days of cardiopulmonary exercise testing and may be supplemented by diagnostic tests like tilt-table testing and the NASA 10-minute lean test [4,5,6]; and

Whereas, ME/CFS can be significantly disabling, leading to challenges with school, work, and activities of daily living[1]; and

Whereas, ME/CFS can leave up to 25% of patients house- or bed-bound, sometimes for years[1]; and

Whereas, Current ME/CFS patients report stigmatization, marginalization, and have increased rates of suicide, in part due to the lack of understanding of their condition by physicians and the general public[3,7,8]; and

Whereas, Fewer than one-third of medical school curricula include information about ME/CFS, leading to a dearth of knowledge about how to diagnose and treat it[3]; and

Whereas, A Center for Disease Control study found that a significant portion of health care providers doubted or had misconceptions about the illness; for instance, a different study further found that 85% of providers thought the illness was wholly or partially psychiatric[3]; and

Whereas, 70% of physicians who had diagnosed a patient with ME/CFS felt the illness was more difficult to diagnose than other illnesses[3]; and

Whereas, An Institute of Medicine report estimates that between 836,000 and 2.5 million Americans suffer from ME/CFS, 90% of whom have not been diagnosed[7]; and

Whereas, The same report found that ME/CFS costs the U.S. economy between $17 to $24 billion annually in medical bills and lost incomes[7]; and

Whereas, A study of Severe Acute Respiratory Syndrome (SARS) survivors unable to return to work due to lingering effects reported that their symptoms closely mirrored those seen in ME/CFS[3]; and

Whereas, A comprehensive study of SARS survivors found that 27.1% met the modified 1994 Centers for Disease Control and Prevention criteria for Chronic Fatigue Syndrome four years after infection[9]; and

Whereas, SARS is a coronavirus with a higher fatality rate than the Coronavirus Disease 2019 (COVID-19) but has similar clinical features[10]; and

Whereas, As of September 20, 2020, the spread of the COVID-19 has led to a global pandemic, with nearly 6.8 million infections and almost 200,000 deaths in the United States alone[11]; and

Whereas, A COVID-19 tracking system found that around 10% of symptomatic but not hospitalized COVID-19 patients had not fully recovered even months later and physicians have begun to report global incidences of post-viral syndromes presenting as chronic, fatigue-related symptoms similar to ME/CFS[7,12]; and

Whereas, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, stated that the post viral symptoms seen in COVID-19 patients are “highly suggestive” of ME/CFS and that it is “something we really need to seriously look at”[13]; therefore be it

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequalae associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequalae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face. (Directive to Take Action)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The term post-viral syndrome includes Myalgic Encephalomyelitis and Chronic Fatigue Syndrome (ME/CFS) and describes a constellation of symptoms that persist after a viral infection including profound fatigue, cognitive dysfunction, sleep abnormalities, autonomic manifestations, and orthostatic intolerance. The effects of ME/CFS can be significantly disabling and interfere with a patient's ability to work and perform activities of daily living.

Despite their debilitating effects, ME/CFS are not widely included in medical school curricula and many physicians possess only a limited understanding of them. In the current COVID-19 pandemic, the long-term effects of the virus are still unknown but a portion of patients have experienced prolonged symptoms that are similar to ME/CFS. Our delegation believes that further research and education regarding ME/CFS would be beneficial in recognizing these syndromes and reducing their harmful effects, especially given the size of the population affected by the COVID-19.

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RELEVANT AMA POLICY

Enhanced Zika Virus Public Health Action - Now D-440.930
1. Our AMA urges Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives.
2. Our AMA will work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus.
3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.
Res. 424, A-16

Funding of Biomedical, Translational, and Clinical Research H-460.926
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research.
Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Viability of Clinical Research Coverages and Reimbursement H-460.965
Our AMA believes that:
(1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;
(2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;
(3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;
(4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;
(5) its current efforts to identify unproven or fraudulent technologies should be enhanced;
(6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;
(7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;
(8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;

(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people;
(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and
(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.
CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation: A-00; Reaffirmed: CMS Rep. 4, A-02; Reaffirmed: CMS Rep. 4, A-12; BOT Action in response to referred for decision: Res. 813, I-15; BOT Action in response to referred for decision: Res. 823, I-15; Reaffirmation: I-18

Support of Biomedical Research H-460.998
Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national goal:
(1) The support of biomedical research is the responsibility of both government and private resources.
(2) The National Institutes of Health must be budgeted so that they can exert effective administrative and scientific leadership in the biomedical research enterprise.
(3) An appropriate balance must be struck between support of project grants and of contracts.
(4) Federal appropriations to promote research in specifically designated disease categories should be limited and made cautiously.
(5) Funds should be specifically appropriated to train personnel in biomedical research.
(6) Grants should be awarded under the peer review system.
(7) The roles of the private sector and of government in supporting biomedical research are complementary.
(8) Although the AMA supports the principle of committed federal support of biomedical research, the Association will not necessarily endorse all specific legislative and regulatory action that affects biomedical research.
(9) To implement the objectives of section 8, the Board will establish mechanisms for continuing study, review and evaluation of all aspects of federal support of biomedical research.
(10) Our AMA will accept responsibility for informing the public on the relevance of basic and clinical research to the delivery of quality medical care.
BOT Rep. S, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CSA Rep. 13, Sunset Report and Reaffirmation, A-00; Reaffirmation I-08; Reaffirmed: BOT action in response to referred for decision: Res. 526, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(JUN-21)

Introduced by: Medical Student Section

Subject: Call for Improved Personal Protective Equipment (PPE) Design and Fitting

Referred to: Reference Committee D

Whereas, The National Institute for Occupational Safety & Health (NIOSH) defines personal protective equipment (PPE) as "equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses[1];" and

Whereas, The NIOSH definition includes items such as gloves, masks, safety glasses and shoes, earplugs or muffs, hard hats, respirators, coveralls, vests and bodysuits[1]; and

Whereas, Currently, "unisex" PPE is designed for European males and does not adequately reflect the diversity in body types[2-6]; and

Whereas, Minorities, especially east Asian racial groups, and women, are more likely to struggle to find PPE that fits appropriately[2-10]; and

Whereas, A 2016 Trade Union Congress survey found that only 29% of women used PPE that was specifically designed for women and that 57% of women reported that improperly fitted PPE sometimes or significantly hampered their work[3,4]; and

Whereas, Improperly-fitted PPE puts users at risk for injuries, including tripping from too large shoes, losing grip on items because of gloves that don't fit, or in some settings, can lead to back pain or foot injuries;[3-6] and

Whereas, During the COVID-19 pandemic, studies have reported healthcare providers developing pressure ulcers from attempting to form a seal with their masks[11,12]; and

Whereas, Improperly-fitted PPE can cause their users added psychological stress due to safety concerns while working[13,14]; and

Whereas, At least some health-care professionals were diagnosed with COVID-19 and were found to have improperly fitted masks[15-,18]; and

Whereas, Properly fitting masks reduce healthcare professionals' risk of contracting COVID-19[15]; and

Whereas, A study of healthcare workers involved in aerosol-generating procedures found that women had an increased hazard ratio of contracting COVID-19 of 1.36 after controlling for confounding factors[17,18]; therefore be it

RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers. (Directive to Take Action)

Fiscal Note: NOT YET DETERMINED

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the availability of PPE for our physicians and care teams since the beginning of this pandemic. However, despite the multitude of policies addressing the importance of clinician PPE (H-440.856, H-295.939, Code of Medical Ethics 8.4), none focus on the importance of well-fitted PPE that differentially fits diverse body types to ensure that all bodies are protected.

There is presently a lack of diversification in the PPE available to protect individuals from certain hazards that can lead to serious injuries and illnesses. Although the PPE is claimed to be "unisex", it has actually been reported to be designed to fit the face and body shape of "a default European male". This leaves a significant portion of individuals in vulnerable positions and we feel that there is an ethical responsibility to work to mitigate this problem. This resolution calls to encourage the development of a broader range of protective equipment, including PPE specifically designed for women's and minorities' bodies. By providing better fitting PPE, we can protect and preserve critically important healthcare workers on the frontlines of the coronavirus pandemic.

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RELEVANT AMA POLICY

Protecting Medical Trainees from Hazardous Exposure H-295.939

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.
2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to mnimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.
Sub. Res. 229, I-92 Reaffirmed: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13 Modified: CME/CSAPH Joint Rep. 01, A-19

8.4 Ethical Use of Quarantine and Isolation

Although physicians' primary ethical obligation is to their individual patients, they also have a long-recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.
With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should:
(a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.
(b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.
(c) Encourage patients to adhere voluntarily to quarantine and isolation.

(d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.
(e) Inform patients about and comply with mandatory public health reporting requirements.
(f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.
(g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.
The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to:
(h) Ensure that quarantine measures are ethically and scientifically sound:
(i) use the least restrictive means available to control disease in the community while protecting individual rights;
(ii) without bias against any class or category of patients.
(i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.
(j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.
(k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.
(l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(JUN-21)

Introduced by: Medical Student Section

Subject: Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles

Referred to: Reference Committee D

Whereas, At the start of the COVID-19 pandemic in March 2020, U.S. hospitals faced critical shortages of essential medical supplies such as personal protective equipment (PPE), testing materials, and ventilators necessary for healthcare management and medical staff safety[1]; and

Whereas, A study found that healthcare workers who were either reusing PPE or had inadequate PPE saw increased hazard ratios of contracting COVID-19 of 1.46 and 1.31 respectively[2]; and

Whereas, On March 19, 2020, President Trump signed the Defense Production Act (DPA) under the pretense of invoking its authority only as a "worst case scenario in the future"[3]; and

Whereas, On March 31, 2020, the AMA called upon President Trump to utilize the DPA to address the severe shortage of PPE in the U.S.[4]; and

Whereas, The Strategic National Stockpile (SNS) was designed to supplement state and local reserves of medical supplies during public health and natural disaster emergencies[5,6,7]; and

Whereas, Former SNS administrators stated that "hospitals and states would create their own stockpiles, and under extenuating circumstances—when they ran out of supplies, or if they were incapacitated for some reason—they could fall back on the national stockpile"[6]; and

Whereas, Even at full capacity, the SNS is incapable of meeting the nation's PPE needs in a pandemic, was only capable of addressing a few states' needs at a time, and was seldom at full capacity due to insufficient Congressional appropriations[8,9]; and

Whereas, At the beginning of the COVID-19 outbreak the SNS contained 12 million of the 3.5 billion N95 masks federal officials estimated were necessary for the pandemic[6,8]; and

Whereas, On April 1, 2020, only a few weeks after the World Health Organization declared a pandemic, the SNS was nearly out of all PPE supplies because it was not restocked after the swine flu pandemic in 2009 and left over supplies had expired[5-11]; and

Whereas, Nationwide shortages in testing materials hindered/set back access to COVID-19 testing, and led to week-long delays for results, both of which resulted in insufficient testing to reduce infection spread[12,13]; and

Whereas, On April 1, 2020, 1.5 million expired N95 masks were distributed to the Transportation Security Administration and Customs Enforcement personnel, however, there are no programs to assess and extend the shelf-life of PPE[7,11];and

Whereas, SNS supplies were distributed both inefficiently and to the wrong locations due to allocations based upon outdated projections[14]; and

Whereas, Alternatives to current PPE distribution methods like computing-based healthcare databases allow for PPE distribution in real time, lowering the cost and increasing distribution effectiveness[15,16]; and

Whereas, The AMA has twice called for the White House Coronavirus Task Force to incentivize the manufacturing and distribution of PPE[17,18]; and

Whereas, On June 26, 2020, in a letter to the Senate Committee on Health, Education, Labor, and Pensions, the AMA highlighted the importance of "creating better coordination across federal and state governments and streamlining pandemic response logistics" and "enhancing state and federal stockpiles and improving the system for acquisition and distribution of medically necessary supplies[19];" therefore be it

RESOLVED, That our American Medical Association amend policy H-440.847 by addition and deletion to read as follows:

Pandemic Preparedness ~~for Influenza~~ H-440.847

In order to prepare for a ~~potential influenza~~ pandemic, our AMA:

(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to ~~an influenza~~ a pandemic or other serious public health emergency;

(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency;

(3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;

(~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

(~~4~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

(7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n influenza~~ pandemic in the United States. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to make substantive amendments to current AMA policy that better aligns with our current advocacy efforts. While our AMA has been a relentless force in advocating for our nation to maintain a stockpile of PPE and infrastructure to better prepare for future pandemics, currently AMA policy is restricted to influenza. This resolution proposes unique ways to amend Policy D-440.847 to address these issues by its language beyond the scope of an influenza pandemic, and adding specific language to encourage the development of the strategic national stockpile.

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RELEVANT AMA POLICY

Pandemic Preparedness for Influenza H-440.847
In order to prepare for a potential influenza pandemic, our AMA:
1. urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency;
2. urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency;
3. urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;
4. supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;
6. will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.
CSAPH Rep. 5, I-12; Reaffirmation, A-15

AMA Role in Addressing Epidemics and Pandemics H-440.835
1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially

infected with Ebola, and widely disseminate such guidelines through its communication channels.
5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.
Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

Code of Medical Ethics Opinion 8.4: Ethical Use of Quarantine & Isolation
Although physicians' primary ethical obligation is to their individual patients, they also have a long-recognized public health responsibility. In the context of infectious disease, this may include the use of quarantine and isolation to reduce the transmission of disease and protect the health of the public. In such situations, physicians have a further responsibility to protect their own health to ensure that they remain able to provide care. These responsibilities potentially conflict with patients' rights of self-determination and with physicians' duty to advocate for the best interests of individual patients and to provide care in emergencies.
With respect to the use of quarantine and isolation as public health interventions in situations of epidemic disease, individual physicians should:
(a) Participate in implementing scientifically and ethically sound quarantine and isolation measures in keeping with the duty to provide care in epidemics.
(b) Educate patients and the public about the nature of the public health threat, potential harm to others, and benefits of quarantine and isolation.
(c) Encourage patients to adhere voluntarily to quarantine and isolation.
(d) Support mandatory quarantine and isolation when a patient fails to adhere voluntarily.
(e) Inform patients about and comply with mandatory public health reporting requirements.
(f) Take appropriate protective and preventive measures to minimize transmission of infectious disease from physician to patient, including accepting immunization for vaccine-preventable disease, in keeping with ethics guidance.
(g) Seek medical evaluation and treatment if they suspect themselves to be infected, including adhering to mandated public health measures.
The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to:
(h) Ensure that quarantine measures are ethically and scientifically sound:
1. Use the least restrictive means available to control disease in the community while protecting individual rights
2. Without bias against any class or category of patients
(i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting.
(j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation.
(k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease.
(l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(JUN-21)

Introduced by: Medical Student Section

Subject: Expansion on Comprehensive Sexual Health Education

Referred to: Reference Committee D

Whereas, Data from the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System indicate that 41.2% of all high school students are sexually active, and 11.5% have had 4 or more partners;[1] and

Whereas, Of the 39 states and D.C. that mandate some form of sex education, only 12 states mandate that sex education be medically accurate, and 16 states mandate that HIV education be medically accurate;[2,3] and

Whereas, Comprehensive sex education is defined as a medically accurate, age appropriate and evidenced-based teaching approach which stresses abstinence and other methods of contraception equally in order to prevent negative health outcomes for teenagers;[4] and

Whereas, A study surveying adolescents aged 15-24 reported over half (60.4% of females and 64.6% males) engaging in fellatio within the past year, while fewer than 10% (7.6% females and 9.3% males) used a condom;[5] and

Whereas, There is a lack of knowledge among adolescents regarding the importance of condoms, dental dams and alternative barrier protection methods use during oral sex to prevent the spread of STIs;[5–7] and

Whereas, When sex education is taught, only 20 states and D.C. require provision of information on contraception;[3] and

Whereas, Several studies have shown parents tasked with teaching their children sexual education frequently needed support in information, motivation, and strategies to achieve competency[8]; and

Whereas, LGBTQ youth are at higher risk for sexual health complications due to differing sexual practices and behaviors;[9] and

Whereas, Current sex education initiatives negatively impact transgender youth and their sexual health by failing to appropriately address their behavior, leading rates of HIV more than 4 times the national average, and increased likelihood to experience coerced sexual contact;[9] and

Whereas, The GLSEN 2013 National School Climate Survey found that fewer than five percent of LGBT students had health classes that included positive representations of LGBT-related topics. Among millennials surveyed in 2015, only 12 percent said their sex education classes covered same-sex relationships;[9,10] and

Whereas, LGBTQ youth are at a significantly higher risk of teen pregnancy involvement (between two and seven times the rate of their heterosexual peers);[11] and

Whereas, When sex education is taught, seven states prohibit sex educators from discussing LGBTQ relationships and identities or require homosexuality to be framed negatively if it is discussed;[3] and

Whereas, in 2010, the federal government redirected funds from abstinence-only programs to evidence-based teen pregnancy prevention programs;[12] and

Whereas, In 2017, 31 federal and state bills were introduced to advance comprehensive sexuality education, but only 4 were enacted or passed;[2,13] and

Whereas, The 2018 CDC School Health Profile determined that only 17.6% of middle schools across all the states taught comprehensive sex education encompassing topics including pregnancy and STIs;[14] and

Whereas, Since 2000, estimated medical costs of $6.5 billion dollars were associated with the treatment of young people with sexually transmitted infections, excluding costs of HIV/AIDS;[15] and

Whereas, 40 states and D.C. require school districts to involve parents in sex education and/or HIV education, of which nearly all states allow parents the option to remove their child from such education;[11] and

Whereas, Some high-risk populations such as teenagers in foster care may not be able to receive adequate reproductive and sexual health education in their home;[16,17] and

Whereas, Regardless of political affiliation, parents overwhelmingly report that sex education is important and should include topics such as puberty, healthy relationships, abstinence, birth control, and STIs;[18] and

Whereas, The rate of teenage pregnancy and STIs in the US has remained consistently higher than many other industrialized countries;[19–21] and

Whereas, The US teen birth rate declined by 9% between 2009 and 2010, with evidence showing that during this time, there was a significant increase in teen use of contraceptives and no significant change in teen sexual activity, highlighting the importance of education on contraception in decreasing teen births[22]; and

Whereas, Studies have found that abstinence-based sex education has insignificant effect on improving teen birth rates, abortion rates, are not effective in delaying initiation of sexual intercourse or changing other sexual risk-taking behaviors, and may actually increase STI rates in states with smaller populations;[23–25] and

Whereas, Comprehensive sex education has been shown to be effective at changing knowledge, attitudes, and behaviors related to sexual health and reproductive knowledge as well as reducing sexual activity, numbers of sexual partners, teen pregnancy, HIV, and STI rates;[23,26–28] and

Whereas, The federal government has recognized the advantages of comprehensive sex education and has dedicated funds for these programs including PREP, a state-grant program from the federal government that funds comprehensive sex education;[29,30] and

Whereas, As of 2017, forty-one PREP programs that emphasize abstinence and contraception equally with a focus on individualized decision making have been vigorously reviewed, endorsed, and funded by the HHS;[29] and

Whereas, Federal funding has increased the amount of funding for abstinence based programs by 67% since the 2018 Consolidation of Appropriations act;[30] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG), Society for Adolescent Health and Medicine (SAHM), and the American Public Health Association have all adopted official positions of support for comprehensive sexuality education;[31–33] and

Whereas, The AMA has existing policy acknowledging the importance and public health benefit of sex education, including Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Health Information and Education H-170.986; and Comprehensive Health Education H-170.977, but falls short of underscoring the importance of comprehensive sex education in schools or advocating for actual implementation; and

Whereas, Lack of funding for comprehensive sex education programs means they are less likely to be taught; therefore be it

RESOLVED, That our American Medical Association amend policy H-170.968 by addition and deletion to read as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ S<u></u>upports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms<u>, dental dams, and other barrier protection methods</u> available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of <u>LGBTQ</u> ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to conduct research and develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
(Modify Current HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Sexual health education has been an important but often neglected topic in the United States. Research indicates that sexual health education is of paramount importance to the wellness and health of adolescents and teens. The current abstinence only until marriage (AOUM) sex education is outdated and does not provide proper support and education to our youths. Medically accurate and comprehensive sexual health education will more than likely decrease the rate of STIs transmission and accidental pregnancies, among many other benefits. The LGBTQ+ community could benefit tremendously from improved training on sexual health education due to increased awareness of complications of unsafe sexual practices as well as promote tolerance towards the community.
This resolution lends much needed focus on utilizing the primary school setting as the principle method of providing medically accurate and comprehensive sexual health education, and does so through a benign amendment to HOD policy.

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RELEVANT AMA POLICY

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;
(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e)

utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
(10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified: Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18

Television Broadcast of Sexual Encounters and Public Health Awareness H-485.994
The AMA urges television broadcasters, producers, and sponsors to encourage **education** about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex.
Res. 421, I-91; Reaffirmed: CSA Rep. 3, A-95; Reaffirmed: CSA Rp. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Health Information and Education H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation: A-07; Reaffirmation: A-15; Reaffirmed: BOT Rep. 15, A-19
Comprehensive Health Education H-170.977
(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades pre-kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug misuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol misuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribe amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach

the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
BOT Rep. X, A-92; Modified: CME Rep. 2, A-03; Reaffirmation: A-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: CSAPH Rep. 01, A-19

HIV/AIDS Education and Training H-20.904
(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.
(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers
Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.
CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(JUN-21)

Introduced by: Medical Student Section

Subject: Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925

Referred to: Reference Committee D

Whereas, Having limited access to healthy and affordable food is recognized as a social determinant of health and disproportionately affects people in particular socioeconomic, racial, and ethnic groups, contributing to existing health disparities[1]; and

Whereas, According to the 2020 United States Department of Agriculture Economic Research Service, 35% of low-income households struggle with food security according to 2018 data[2]; and

Whereas, More than 13 million US children lived in food-insecure households, which are described as homes where they lacked access to sufficient food to support a healthy and active lifestyle, and rates of food insecurity are twice as high among Black and Hispanic households compared to White households[3-4]; and

Whereas, Food insecurity across a child's first 5 years of life is associated with poorer outcomes on a range of family well-being indicators, lower levels of mental health, and higher levels of family conflict[3]; and

Whereas, Food insecurity showed that adults aged 20-39 had higher odds of having prediabetes/diabetes due to greater consumption of carbohydrates and less protein, a pattern that is linked to Types DM progression[5]; and

Whereas, The American Academy of Pediatrics and the American Academy of Family Physicians recognizes food insecurity as a major social determinant of health and advocates for federal and local policies that support access to adequate healthy food[6-7]; and

Whereas, A food desert is defined as an area that lacks access to affordable and healthy food and is typically used to describe low-income rural and urban neighborhoods that either do not have a nearby grocery store or where a large portion of residents are unable to travel to or afford the existing healthy food[8]; and

Whereas, A food swamp is defined as an area with abundant access to unhealthy foods and fast food restaurants and limited access to healthy foods and grocery stores[9]; and

Whereas, A food mirage is defined as an area where grocery stores exist but their prices make them inaccessible to low-income families[10]; and

Whereas, The lack of access to healthy foods and increased prevalence of low price stores that promote junk foods are important factors in obesity and chronic disease among individuals in a food desert[11]; and

Whereas, According to The Food Trust "A study of nearly 4,000 adults living in New Orleans found that each additional supermarket in a participant's neighborhood is associated with reduced risk for obesity, while fast-food and convenience store access are predictive of greater odds of obesity"[12]; and

Whereas, An estimated 13.5 million people in the United States have low access to a supermarket or large grocery stores, with 82% of these individuals living in urban areas[8]; and

Whereas, 23.5 million people live in low-income areas that are more than 1 mile from a supermarket, which represents 8.4% of the US population[8]; and

Whereas, In any given year, 13% of households are car-less and 45% of families in poverty do not own a car[13-14]; and

Whereas, Many low-income households cannot afford the cost of traveling to a supermarket outside their neighborhood[15-16]; and

Whereas, Minority communities are frequently found to have decreased availability of supermarkets, grocery stores, and affordable healthy foods and increased prevalence of convenience stores and fast food restaurants[17-19]; and

Whereas, The defining characteristic of communities with limited food access are higher levels of racial segregation and income inequality in urban areas and lack of transportation infrastructure in rural areas[20]; and

Whereas, According to the Robert Wood Johnson Food Foundation, the federally funded community-based Healthy Food Financing Initiative (HFFI) supported Mandela Partners' distribution of "650,000 pounds of fresh produce, 46% of which comes from small family farms within 200 miles of Oakland, helping keep farmers on the land and increasing their income by over $300,000", and "increasing access to nutritious food in low-income communities and communities of color" [21-23]; and

Whereas, Implementation of the community-based Healthy Navajo Stores Initiative to increase produce availability in a food desert and the Navajo Fruit and Vegetable Prescription Program (a food voucher program) resulted in a significant increase in the likelihood of individuals purchasing produce, especially at independently owned stores, and in one study cohort, participating families increased their produce consumption by 48% and child BMI decreased by 41%[24-25]; and

Whereas, Non-profit and community-driven supermarket interventions in food deserts have been shown to be more likely to remain open long-term compared to government-driven or commercial-driven models, suggesting that community engagement is a necessary component of sustainable food access interventions[26]; and

Whereas, Current AMA policy (D-150.978) expresses the need for healthcare to support and model ecologically sustainable food systems and "encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation"; and

Whereas, Current AMA policy (H-150.925) only encourages the study of problems concerning "food mirages, food swamps, and food oases as food environments distinct from food deserts", there is no policy highlighting the importance of food access on health and health inequality; therefore be it

RESOLVED, That our American Medical Association amend policy H-150.925, "Food Environments and Challenges Accessing Healthy Food," by addition and deletion as follows,

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation priorities protections and health of marginalized or vulnerable populations, including access to nutritious foods. This resolution asks the AMA to amend H-150.925 to recognize that food access inequities disproportionally impact marginalized communities and that community-level initiatives, versus federally-based programs, pose a sustainable solution to these challenges.

Healthy food access is a critical component of healthy societies. Inequitable access to nutritious food, especially during this pandemic, has increased the utilization of food banks in marginalized communities and underscores the need for healthy, resilient food infrastructure. While existing AMA policy supports healthy food initiatives, the intersectionality between food access and socioeconomic or racial status has not been previously defined. Our delegation believes this resolution will strengthen our AMA policy beyond studying the well-researched national prevalence, impact, and solutions of food access to include an acknowledgment of the effects of food access inequality on marginalized communities and people of color and the need to empower and support these communities.

References:

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RELEVANT AMA POLICY

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.
Res. 921, I-18

Sustainable Food D-150.978
"Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.
CSAPH Rep. 8, A-09; Reaffirmed in lieu of: Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of: Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation: A-12; Reaffirmation: A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation: A-14; Reaffirmation: I-14; Reaffirmation: A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Res. 021, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(JUN-21)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee D

Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively homosexual behavior to exclusively heterosexual behavior[1]; and

Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2% of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or bisexual[2]; and

Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual sexual behavior as patients may not be willing to report their sexual histories accurately[2]; and

Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the men who have sex with men (MSM) demographic[3]; and

Whereas, From 2010-2016, African American heterosexual women accounted for the second highest incidence of HIV infection after MSM[4]; and

Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to be the "bridge" through which HIV has been transmitted to black heterosexual men and women[5-6]; and

Whereas, Several studies have shown that African American MSMW may challenge targeted HIV prevention approaches that focus explicitly on sexual orientation since this population may not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize gay community affiliation as foundations for HIV prevention[5-6]; and

Whereas, In 2017, the African American population and Hispanic population collectively accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population[3]; and

Whereas, A report from the CDC concluded that increasing HIV prevention services among heterosexuals at increased risk is important, especially among racial and ethnic groups disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos[7]; and

Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces the risk of sexual transmission of HIV by about 99% when taken daily[8-9]; and

Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million additional individuals would benefit from being on it[10-13]; and

Whereas, 69% of the individuals that could benefit from PrEP are Black or Hispanic, yet these individuals comprise only 4% of the individuals that are prescribed it[11-12]; and

Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the United States, as people of color and women bear a high HIV burden, but have a disproportionately limited uptake[14]; and

Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the most frequently cited barrier to prescribing it being lack of knowledge[15-16]; and

Whereas, A 2018 study showed that medical students were unable to identify individuals at highest risk of HIV acquisition and recommend PrEP accordingly[17]; and

Whereas, Educational interventions targeted at primary care physicians that focus on HIV epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to increase rates of PrEP prescribing when clinically indicated[16]; and

Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality, contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as early as age 11[18-19]; and

Whereas, It is considered a best practice in primary care settings to educate patients about all the available options for preventing STIs, especially in sexually active adolescents and in adults at increased risk for STIs[18-19]; and

Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients[8,15]; and

Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP uptake, was suggestion to initiate PrEP by a healthcare provider[14]; and

Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective medical diagnosis and treatment"; and

Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the consistency and equity of care for all persons" and "supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations"; and

Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV prevention and treatment nor proposes a specific intervention to reduce such disparities; therefore be it

RESOLVED, That our American Medical Association amend AMA Policy H-20.895 "Pre-Exposure Prophylaxis (PrEP) for HIV," by addition to read as follows:

Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient's current reported sexual behaviors. (Modify Current HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to reduce existing disparities through universal PrEP counseling. Our delegations believe that this resolution will add significant value to LGBTQ+ health. Universal PrEP counseling also addresses the stark underutilization of PrEP by many vulnerable populations, including Black heterosexual women and queer and trans people of color. While recent years have seen significant uptake by white and wealthier members of the LGBTQ community, true improvement in the health of our community as a whole and addressal of the health disparities within our community requires increased PrEP knowledge and use among queer and trans people of color as well as low-income LGBTQ individuals. Finally and most importantly, this resolution emphasizes patient-centered care: with proper, universal counseling around preventive measures against a chronic condition with high prevalence and morbidity, patients can make their own informed decisions about what the best preventive practice looks like for their own sexual practices and their own lives.

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Reaffirmed: CSAPH Rep. 01, I-18

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.
Modified: Res. 16, A-18

Improving the Health of Black and Minority Populations H-350.972
Our AMA supports:
1. A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
2. Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
3. Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
4. The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
BOT Rep. 33, A-18

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
a. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
b. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
c. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Reaffirmed: CMS Rep. 10, A-19

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896
1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.
Appended: Res. 413, A-19.

HIV/AIDS Education and Training H-20.904
(1) Public Information and Awareness Campaigns
Our AMA:
a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.
(2) HIV/AIDS Education in Schools
Our AMA:
a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;

b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(JUN-21)

Introduced by: Medical Student Section

Subject: Student-Centered Approaches for Reforming School Disciplinary Policies

Referred to: Reference Committee D

Whereas, School-related arrests and juvenile justice referrals have been associated with school disengagements, lower graduation rates, increased dropout rates, and increased involvement in the school-to-prison pipeline[1, 2]; and

Whereas, School-related arrests and juvenile justice referrals disproportionately target black students, Latino students, male students, and students with physical or mental disabilities[3, 4, 5]; and

Whereas, Research on the effectiveness of school resource officer programs is limited, and fails to make a strong case for harsh discipline programs that include referral to law enforcement[6]; and

Whereas, School-based mental health efforts have been successful in identifying those in need of mental health services, bolstering academic functioning, and improving patterns of behavior[7]; and

Whereas, Educators, nurses, and counselors can play a key role in fostering protective environments for children and identifying students who may need additional support, in contrast to school resource officers[8, 9]; and

Whereas, School-based mental health professionals report ever-increasing workloads and responsibilities that include disciplinary roles[10, 11]; and

Whereas, Students report feeling hesitant to approach counselors to discuss academic, mental health, or social issues because they do not feel that their disclosure will be kept private, possibly affecting their academic or conduct standing[12]; and

Whereas, The American School Counselor Association urges that “school counselors maintain non-threatening relationships with students to best promote student achievement and development” and states that school counselors are neither “disciplinarians” or “enforcement agent[s] for the school”[13]; and

Whereas, The National Association of School Nurses states that school nurses should facilitate an “environment that values connecting students, families, and the community in positive engagement” characterized by “safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf”[14]; and

Whereas, Positive Behavior Interventions and Supports (PBIS) is an evidence-based implementation framework focusing on prevention and intervention strategies that support the

academic, social, emotional, and behavioral competence of students at all levels of education[15]; and

Whereas, PBIS promotes prevention of student misbehavior by having students experience "predictable instructional consequences for problem behavior without inadvertent rewarding" while educators provide "clear and predictable consequences for problem behavior and following up with constructive support to reduce the probability of future problem behavior"[15]; and

Whereas, PBIS was shown in a group randomized controlled effectiveness trial of 12,344 elementary students to reduce concentration and behavioral problems, and increase social-emotional functioning and prosocial behavior[16]; and

Whereas, PBIS implementation has been linked to positive outcomes in attendance, behavior, and academics while decreasing office discipline referrals, in-school suspensions, and out-of-school suspensions[17, 18]; and

Whereas, Mental Health America and the American Academy of Pediatrics have recognized the detrimental effects of "zero tolerance" policies and have advocated for school wide PBIS as an alternative[19, 20]; and

Whereas, AMA policy H-60.919 includes support for "school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments," but is largely focused on determination of punishment rather than prevention of misbehavior; and

Whereas, AMA policy H-60.991 establishes the role of school-based health programs and AMA policy H-60.902 addresses the need for policy ensuring proper qualification and training for school resource officers, but do not delineate if or how school-based health professionals should participate in school disciplinary roles; therefore be it

RESOLVED, That our American Medical Association support evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy)

Fiscal Note: not yet determined

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We believe that this resolution addresses an important policy gap as it expands on the current policies that exists concerning school discipline. It asks AMA to work with education stakeholders to determine appropriate roles for mental-health professionals in schools, with particular respect to disciplinary processes. Policies H-345.977 and H-345.981 already allow for the inclusion of mental health screening in schools and encourage leveraging 'firstline contacts' to intervene with students such as those with repeat instances of misbehavior. This resolution, in contrast, focuses on the prevention of student misbehavior and the prioritization of their behavioral health outcomes.

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RELEVANT AMA POLICY

Juvenile Justice System Reform, H-60.919

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development andlocal public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.
(CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16)

School-Based and School-Linked Health Centers, H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
(CSAPH Rep. 1, A-15)

Adolescent Health, H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.
(Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed CSAPH Rep. 01, A-17)

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.
(CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)

Improving Pediatric Mental Health Screening, H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
(Res. 414, A-11; Appended: BOT Rep. 12, A-14)

Access to Mental Health Services, H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment.
(CMS Res. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11, Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18)

School Resource Officer Qualifications and Training, H-60.902
Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.
(Res. 926, I-19)

Reference Committee E

CSAPH Report(s)

02* Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings

Resolution(s)

501 Ensuring Correct Drug Dispensing
502 Scientific Studies Which Support Legislative Agendas
503 Access to Evidence-Based Addiction Treatment in Correctional Facilities
504* Healthy Air Quality
505* Personal Care Product Safety
506* Wireless Devices and Cell Tower Health and Safety
507* Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues

** Contained in the Handbook Addendum*

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June 2021)
Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings
(Reference Committee E)

EXECUTIVE SUMMARY

Objective. The term "excited delirium" (ExD) is controversial and lacks a defined set of behavioral signs and symptoms used to identify a person in distress and in need of urgent medical or psychiatric help. Additionally, several media reports have recently highlighted the use of ketamine and other sedative/hypnotic agents by non-medical professionals to chemically incapacitate a person for a law enforcement purpose, and in many cases, ExD is listed as the reason for the use of a sedative/hypnotic agent. The Board of Trustees has requested that the Council on Science and Public Health study the use of ketamine and chemical restraints in the context of "excited delirium" and report back to the House of Delegates.

Methods. English-language reports were selected from a PubMed and Google Scholar search using the text terms "excited delirium," "delirium," "fatalities excited delirium," "excited delirium restraint," "excited delirium sedatives," "excited delirium ketamine," "police ketamine," "EMS ketamine," and "crisis response team." Articles were filtered based on relevance. Additional articles were identified by manual review of the references cited in these publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. The assessment, diagnosis, and treatment of ExD remains controversial. Despite a lack of scientific evidence, a universally recognized definition, a clear understanding of pathophysiologic mechanisms, or a specific diagnostic test, law enforcement and EMS personnel are taught that ExD is a potentially deadly medical condition. Even deaths attributed to ExD have no consistent anatomical findings, resulting in ExD diagnosis being one of exclusion, defined by epidemiology and the subjective description of a clinical presentation. The individuals most likely to be disproportionately identified as experiencing ExD, and to die from resulting first responder actions, or as a consequence of administration of chemical sedation for a presumed case of ExD, are otherwise healthy Black males in their mid-30s who are viewed as aggressive, impervious to pain, displaying bizarre behavior, and using substances – characterizations that may be based less on evidence and more on generalizations, misconceptions, bias, and racism. Additionally, the identification of ExD has frequently been used in defense cases of law enforcement violence, despite reported autopsy results listing asphyxiation as the cause of death.

Conclusion. Reviews of law enforcement agencies and EMS have been called for to evaluate the prevalence of ketamine use in the field in unmonitored individuals and also to assess that training and guidelines for law enforcement and EMS have been established by supervising medical and behavioral health specialists. Such reviews are appropriate. It is important to assure that de-escalation training be widely implemented, and that personnel are conducting themselves according to guidelines and training to ensure patient safety. New crisis intervention team models in which medical and behavioral health specialists, not police, are those first deployed to respond to behavioral emergencies in the community should be encouraged. These models can help assure that decision makers in medical and mental health emergencies who are most appropriate to the circumstances are present with first responders, and that administration of any pharmacological treatments in a non-hospital setting is done equitably, in an evidence-based, anti-racist, and stigma-free way.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-JUN-21

Subject: Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee E

BACKGROUND

Recent media reports refer to "excited delirium" in discussions about police brutality and the use of conducted electrical devices (CED).[1-4] The term "excited delirium" is controversial and lacks a defined set of behavioral signs and symptoms used to identify a person perceived as in distress and in need of urgent medical or psychiatric help. Additionally, several media reports have recently highlighted the use of ketamine and other sedative/hypnotic agents by non-medical professionals to chemically incapacitate a person for a law enforcement purpose and not for a legitimate medical reason.[4-6] In many cases, "excited delirium" is listed as the reason for the use of a sedative/hypnotic agent. The AMA Board of Trustees has requested that the AMA Council on Science and Public Health study the use of ketamine and chemical restraints in the context of "excited delirium" and report back to the AMA House of Delegates.

METHODS

English-language reports were selected from a PubMed and Google Scholar search using the text terms "excited delirium," "delirium," "fatalities excited delirium," "excited delirium restraint," "excited delirium sedatives," "excited delirium ketamine," "police ketamine," "EMS ketamine," and "crisis response team." Articles were filtered based on relevance. Additional articles were identified by manual review of the references cited in these publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

AMA POLICY

No current AMA policy exists related specifically to excited delirium or the use of chemical restraints by law enforcement. AMA Policy H-515.968, "Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohypnol," emphasizes that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. Policy H-345.979, "Evaluation of Delirium," supports efforts to educate physicians regarding the importance of evaluation of delirium for high-risk patients and patients who are symptomatic.

AMA has several polices related to law enforcement that are applicable to the topic of this report. Policy H-65.954, "Policing Reform," recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA's willingness to work with interested national, state, and local medical societies in a public

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health effort to support the elimination of excessive use of force by law enforcement officers, states that AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures, and will advocate for legislation and regulations which promote trauma-informed, community-based safety practices. Policy H-345.972, "Mental Health Crisis Interventions," supports jail diversion and community based treatment options for mental illness, implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, federal funding to encourage increased community and law enforcement participation in crisis intervention training programs, and legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities. Policy H-145.977, "Use of Conducted Electrical Devices by Law Enforcement Agencies," recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of CEDs that is modeled after available national guidelines, encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use, and urges law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs.

AMA has policy related to Emergency Medical Services (EMS) and prehospital patient care. Policy H-130.976, "On-Site Emergency Care" reaffirms endorsement of the concept of appropriate medical direction of all prehospital emergency medical services and notes that trauma management differs markedly between locales, settings, and types of patients receiving care and for these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly. Policy H-160.949, "Practicing Medicine by Non-Physicians" opposes allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision and supports the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. Policy H-130.937, "Delivery of Health Care by Good Samaritans" notes that bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system.

Ethical Opinion 1.2.7, "Use of Restraints," states that all individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient. Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing. Physicians who order chemical or physical restraints should: (a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient. (b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate: (i) why restraint is recommended; (ii) what type of restraint will be used; (iii) length of time for which restraint is intended to be used. (c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record. In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed.

EXCITED DELIRIUM

Delirium is a well-defined clinical entity with both hypoactive and hyperactive manifestations, commonly caused by an underlying medical condition and not associated with sudden death. The term "excited delirium" (ExD) has been used since the 1980s to refer to a subcategory of delirium that has primarily been described in forensic literature and the term "excited delirium syndrome" (ExDS) was originally used in the forensic literature to describe findings in a subgroup of patients with ExD who suffered lethal consequences from untreated severe agitation. Currently, ExD and ExDS are used interchangeably in literature and media.

History

In 1849, the lead psychiatrist at McLane Asylum for the Insane introduced a condition synonymous to ExD into medical literature as "Bell Mania."[7] The term "excited delirium" first emerged in 1985 from two University of Miami professors who set out to explain a new phenomenon of sudden deaths, mostly in police custody, of otherwise healthy men under the influence of a non-lethal amount of cocaine.[8,9] Soon after, the term gained academic traction, as the United States saw a dramatic rise in use of cocaine and other sympathomimetic substances along with increased efforts to deinstitutionalize patients with chronic mental illness.[10] Currently, ExD and ExDS are referred to as conditions of illness marked by a combination of autonomic hyperadrenergic dysfunction, agitation, and delirium. The purported root of ExD, involving psychiatric, neurologic, and metabolic imbalance, is highly variable and linked to a complicated array of co-morbid and severe health issues.[11]

Historically, the concept of ExD was synonymous with death, but over time the term has made its way into the emergency medicine, psychiatric, law enforcement, prehospital, and medicolegal literature to generally describe patients displaying altered mental status with severe agitation and perceived combative or assaultive behavior that has eluded a unifying, prospective clinical definition. Studies have failed to define ExD as one specific clinical entity, and it remains without a plausible biological pathway to sudden death. Multiple published series highlight that when CEDs and/or police restraints are used, ExD most often becomes fatal.[12-17] CSAPH Report 6-A-09, *Use of Tasers® by Law Enforcement Agencies*, included a very brief paragraph on ExD and notes that ExD is not a validated diagnostic entity in either the World Health Organization's International Classification of Diseases or the *Diagnostic and Statistical Manual of Mental Disorder*s, but is widely accepted in forensic pathology and is cited by medical examiners to explain the sudden in-custody deaths of individuals who are combative and highly agitated.[18]

Pathophysiology

Although it is extensively used in academic and medical literature, considerable debate exists in medicine about how to characterize ExD and ExDS, if they even exist, and how ExD contributes to sudden death. The pathophysiologic mechanisms of ExD have not been elucidated and ExD does not currently have a known etiology.[10,19-21] However, ExD has been characterized in the literature by delirium, agitation, acidosis, and hyperadrenergic autonomic dysfunction, typically in the setting of drug use or serious mental illness or a combination of both.[11] Currently, a general function of the sympathetic nervous system is associated with the listed clinical manifestations of ExD, with possible nervous system dysfunction in some way inciting symptoms. While some authors correlate elevated synaptic dopamine levels to ExD, its causes are yet to be discovered and the absence of a unique pathophysiologic cause or specific diagnostic test remains.[22-24]

No consistent anatomical features define ExD. Due to the biological ambiguity in diagnosing ExD, postmortem findings from autopsy and forensic evidence collection to identify or support ExD are unlikely, and a postmortem diagnosis of ExD is one of exclusion.[8,17,25,26] Because ExD does not currently have a known specific etiology or a consistent anatomic feature, it can only be explained by its epidemiology and described clinical presentation.[20]

Epidemiology

Studies have shown that delirium occurs in between 11 and 42 percent of general medical inpatients and 50 percent of elderly hospitalized patients. This figure is even greater for those with pre-existing cognitive impairments, terminal illness, or in need of intensive care.[27] Patients diagnosed with delirium are found to have extended stays in the hospital by five to ten additional days, and are more likely to be transferred to a long-term care facility post-release.[28]

Those who are most likely to be identified as having ExD are men, with 83 to 95 percent of ExD cases occurring in this population.[24] Otherwise healthy males in their mid-30s who are seen as "aggressive, impervious to pain, and display bizarre behavior" have the highest rate of mortality from ExD/ExDS.[10] Despite similar rates of drug use across race and ethnicity in the United States,[29] epidemiological studies show that it is specifically and disproportionately younger Black men who use cocaine and other psychostimulants and are in police custody that are at highest risk for death from ExD/ExDS.[24,30,31] Mortality rates associated with ExD/ExDS have been reported to be between 8 to 16.5 percent.[11,24,32]

LAW ENFORCEMENT, EMS, AND EXCITED DELIRIUM

Because of its reference in forensic literature, law enforcement groups and EMS have started training staff to identify ExD as a potentially deadly medical condition, despite the absence of a unique pathophysiologic cause or specific diagnostic test.[33,34] ExD often presents itself as a behavioral issue initially evaluated by law enforcement with subsequent EMS involvement.[11,35] Additionally, the identification of ExD/ExDS has been frequently used in defense cases of police violence.[9,36] Some of the cases in which ExD has been invoked in defending the deaths of people, all Black, in police custody include Natasha McKenna,[14] Manuel Ellis,[2] Elijah McCain,[5] George Floyd,[3] and Daniel Prude.[1]

The prevalence of ExD appears to vary widely, both because of varying definitions and context. Reports estimate that ExD is in question in more than 3 percent of police interventions that use force and more than 10 percent of the deaths that occur within law enforcement custody are associated with ExD.[24] Reports also note that between 38 and 86 percent of all fatal ExD cases occur in police custody[24] and that law enforcement officers encounter one person with ExD in every 58 use of force incidents.[25] In cases of suspected ExD, law enforcement officers are encouraged to contact EMS personnel; the combined effort of EMS and law enforcement to provide effective care to those with ExDS has been termed the "dual response."[33,34] Training for EMS personnel states that treatment of ExDS must be focused on rapidly, safely, and effectively sedating the patient and providing intensive, supportive care.[37]

Since ExD lacks a consensus clinical definition and few pathophysiological findings exist about the condition, wrongly characterizing symptoms as ExD, especially by law enforcement with little medical knowledge, frequently leads to additional and potentially fatal medical complications including hypoxia.[17,38-40] The profile of a death attributed to ExD is usually a sudden, unexpected one that occurs most frequently in the summer.[41] It usually occurs immediately following chemical or physical restraint to control ExD and occurs most frequently when the patient is in the prone

position; both chemical restraints and CEDs have been cited to result in sudden death due to ExD.[15,17,42] An *FBI Law Enforcement Bulletin* article discussing ExD describes it as "a serious and potentially deadly medical condition involving psychotic behavior, elevated temperature and an extreme flight-or fight response," and notes that "these patients often die within 1 hour of police involvement."[33]

Studies have evaluated the factors associated with death attributed to ExD in police custody and the confounding effect that restraint has on the risk of death. Results have indicated that a diagnosis of ExD and potentially fatal restraint are "inextricably interwoven."[43,44] Some form of restraint was described in 90 percent of all ExD deaths, making it the most common factor that is a plausible cause or contributing cause of the death. Authors note that there is no evidence to support ExD as a cause of death in the absence of restraint.[44] The reported autopsy results for the individuals referenced above, in which law enforcement officers cited ExD as the cause of death provide examples of this: in the death of Natasha McKenna, "excited delirium," was noted although a stun gun was utilized 4 times resulting in loss of consciousness;[14] the death of Elijah McClain was "undetermined," although carotid hold and excessive restraint were utilized;[5] the death of Manuel Ellis was reported as "hypoxia due to physical restraint;"[2] George Floyd died from "asphyxia due to neck and back compression;"[3] and Daniel Prude's death was due to "complications of asphyxia in the setting of physical restraint."[1]

While the mortality rate associated with ExD is estimated to be between 8 and 16.5 percent,[11,24,32] in the past three decades, a significant decrease in restraint-related deaths of those with ExD has been noted. The period from 2004 to 2011 shows a 33 percent reduction in fatalities from ExD compared to the period 1988 to 1995; authors comment that the decrease is likely due to an increase in warnings and repeated recommendations concerning the association between restraint, especially in a prone position and fatal ExD.[24] However, little information related to the specific details of law enforcement or EMS training related to ExD could be located.

CHEMICAL RESTRAINT

A chemical restraint is when a drug is used to restrict the movement of a patient or in some cases to sedate a patient. Chemical restraint is used in emergency, acute, and psychiatric medical settings to reduce agitation, aggression, or violent behaviors. Drugs that are often used as chemical restraints include benzodiazepines, antipsychotics, and dissociative anesthetics. However, no drugs are U.S. Food and Drug Administration (FDA) approved for use as chemical restraints. The long history of restraint and associated controversies of the use of restraints (physical, mechanical, and chemical) in patients is outside of the scope of this report.

Drugs Used as Chemical Restraints

Medications that are typically used for chemical restraint include the dissociative ketamine, benzodiazepine sedatives such as midazolam, and antipsychotic medications including olanzapine or haloperidol, both alone or in combination.

Studies over the last several years have evaluated and compared the efficacy of sedation for several medications used for chemical restraint, as well as adverse effects associated with them.[45-49] A recent systematic review summarizes available evidence on the effectiveness and safety of chemical restraint from 21 randomized controlled trials conducted in pre-hospital, hospital emergency department, or ward settings and notes limited comparability between studies in drug choice, combination, dose, method of, or timing of repeat administrations. Drugs used in chemical restraint and included in the review include olanzapine, haloperidol, droperidol, risperidol,

flunitrazepam, midazolam, promethazine, ziprasidone, sodium valproate, or lorazepam. The review notes little clarity about the superiority of any of the drugs and recommends additional research on the topic.[50]

Because sedation with slower-onset chemical restraints, such as haloperidol and some benzodiazepines present a risk of delay to adequate sedation, ketamine has emerged as a potentially preferred drug for the control of patient agitation in a pre-hospital context and for a law enforcement purpose.[35,37,39,40,51-54] Although little literature exists directly reporting the frequency of EMS use, authors note that this medication could easily be implemented into out-of-hospital protocols and that ketamine offers a "safe and effective method of controlling the severely agitated patient."[35,37]

Ketamine

Ketamine is FDA approved for use as an anesthetic agent for diagnostic and surgical procedures and esketamine (a pure ketamine stereoisomer) is FDA approved for treatment-resistant depression. Ketamine and esketamine are classified as Schedule III controlled substances.

Ketamine is commonly used off-label in medical settings as an analgesic, antidepressant, and anti-inflammatory medication. No FDA-approved indication for use to treat ExD exists, which is understandable given that there is no medical consensus on definitions of or diagnostic criteria for ExD. Therefore, no standard dosing regimen has been established and there has been no consideration of co-morbid medical conditions for ketamine use for ExD. A rapidly growing movement calls for expanded use of ketamine for several applications, both in and out of the hospital, including for sedation of agitated patients in non-clinical situations and for restraint in custody.[35,55]

Ketamine Use as a Chemical Restraint by Law Enforcement and EMS

Police officers and EMS professionals are the most likely first responders to encounter agitated patients exhibiting what they might consider to be symptoms of ExD. While law enforcement usually evaluates this syndrome, it is usually EMS personnel who provide the sedation, in the "dual response" model. While several chemical restraints are used to sedate those purportedly experiencing ExD within law enforcement custody and in EMS contexts, most commonly the sedative is ketamine. Authors report that the use of ketamine for restraint of an agitated patient induces rapid, predictable sedation within three to four minutes when given by intramuscular injection.[37,54,56]

A recent national survey assessed ketamine training, use, and perceptions among paramedics in civilian prehospital settings. The survey noted that training related to ketamine use was commonly reported among paramedics, however, few are authorized to administer the drug according to their agency protocol. Of those paramedics authorized to use ketamine, most had limited experience administering the drug, but have the perception that the use of ketamine for sedation is safe and effective.[52] Dosing guidelines, safety profile, and efficacy have been described in only a limited fashion for the use of ketamine to chemically restrain a patient in a pre-hospital scenario.[51]

Many police departments have seen a dramatic rise in ketamine administration over the past several years. As an example, a 2018 City of Minneapolis report "MPD Involvement in Pre-Hospital Sedation" documented an average of 4 cases of ketamine use per year prior to 2015, 14 uses in 2015, and 62 instances in 2017.[57] From January 2018 through April 2018, 11 instances of ketamine use were documented in police reports, exceeding the annual use in each year from 2010-2014.[57]

Additionally, the report from Minneapolis presented 8 cases that occurred between 2016 and 2018 in which EMS professionals and Minneapolis Police Department (MPD) officers cooperated in order to administer ketamine. These cases involved instances in which the police officers, with limited medical training, directed EMS professionals to use ketamine.[57] A recent investigation of the death of Elijah McCain in Colorado determined that the use of ketamine contributed to his death.[58]

Little information related to the specific details of law enforcement or EMS training related to the use of ketamine or other chemical restraints could be located. Reviews of law enforcement agencies and EMS have been called for to evaluate the prevalence of ketamine use in the field in unmonitored individuals and to assess that training and guidelines have been established by supervising medical and behavioral health specialists, are appropriate, include de-escalation training, and personnel are conducting themselves according to guidelines and training to ensure patient safety.[35,57,58] Additionally, agencies currently using ketamine for sedation of agitation are encouraged to report their outcomes and protocols to increase the body of evidence and determine best safe practices for this indication.[35]

Ketamine Pharmacology in Pre-hospital Contexts

Ketamine dose dependently exerts broad influences on consciousness and perception, with some patients reporting dissociative and extracorporeal sensations. The most common psychoactive effects reported after a single subanesthetic intravenous administration of ketamine include dissociation, positive psychotomimetic effects (conceptual disorganization, hallucinations, suspiciousness, unusual thought content, and frank paranoia), and negative psychotomimetic effects (blunted affect, emotional withdrawal, and psychomotor retardation). In addition, studies have identified unfavorable effects of administration of ketamine on cognition (including amnesia), vestibular perturbations, nausea/vomiting, tachycardia, hypertension, palpitations, hypersalivation, and respiratory depression. Ketamine has also been found to have negative interactions with alcohol in intoxicated individuals and those taking MAO inhibitors, which is of concern because when ketamine is used by EMS in out-of-hospital settings, individuals may be under the influence of alcohol, cannabis, sedative-hypnotics, or other psychoactive drugs or under medical treatment with a pharmaceutical with potential adverse drug-drug interactions with ketamine.[48,59-62]

Because of the ketamine dose-response and side effects, careful administration and medical expertise is necessary, especially in non-medical and non-hospital contexts.[17,38-40] In general, the duration of sedation should only be long enough to allow for patient assessment, initial treatment, and transfer to a medical facility; restraint beyond this timeframe may induce additional medical complications. Ketamine dosing is dependent on a person's body weight, with a reported standard dosing of 5mg per kilogram of bodyweight starting at 250 mg for pre-hospital treatment.[44,51,63,64] Because of this weight dosing requirement, incorrect dosing of ketamine by law enforcement or EMS can and has led to serious adverse events or death.[58] A recent investigation of the death of Elijah McClain in Aurora, Colorado found that an incorrect estimation of weight for a weight-based dose calculation contributed to his death.[58] Additionally, several studies have reported that while ketamine provides rapid sedation for agitated patients, its use in a pre-hospital setting is associated with higher intubation and hospital admission rates when used by EMS.[35,38,48,51,54,60,62,65,66] Studies have also linked the use of ketamine to death from metabolic acidosis.[67-69]

CRISIS INTERVENTION TEAM PROGRAMS

Crisis Intervention Team programs (CITs) are community partnerships of law enforcement, behavioral health providers, people with mental and substance use disorders, along with their families and others. CITs have become a globally recognized model for safely and effectively assisting people who experience crises in the community. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that the need for CIT programs is urgent, as communities are challenged with insufficient mental health funding and services.[70] Advocates of CITs, including the National Alliance on Mental Illness (NAMI), note that the programs can reduce police encounters and arrests of people with mental illness while simultaneously increasing the likelihood that individuals will receive mental health services.[71-73] Additional goals of CITs include improving police responses to people in crisis; diverting individuals from the criminal justice system when appropriate; and developing more robust community-based crisis-response systems that minimize both the role of law enforcement and the need to utilize emergency departments.[74] A foundational aspect of successful CITs is a strong and ongoing community partnership.[74]

CITs promote both law enforcement officer safety and the safety of the individual in crisis. NAMI notes that CITs give law enforcement officers more tools to do their job safely and effectively and promotes the expansion of CITs nationwide, providing resources and working with stakeholders to establish standards and promote innovation for CITs.[73] While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is core to the model. SAMHSA notes that for safety and optimal engagement, two person CIT teams should be put in place to support communities and EMS should be aware of the teams and partner as warranted. SAMHSA guides also note minimum expectations for CITs, including the involvement of a licensed and/or credentialed behavioral health clinician, response to where the person in need is located, and connecting the individual to appropriate care, with a warm hand-off and coordinated transportation. SAMHSA guides and CIT International, the leading national organization promoting successful CIT models, detail best practices for CIT services[75,76] and experts have documented and noted challenges for rural communities.[77]

The Denver Support Team Assisted Response program (STAR), which has been operational for six months, is an example of a CIT. STAR pairs a mental health clinician and a paramedic to address low-level incidents, such as trespassing and mental health episodes, that would have otherwise fallen to uniformed law enforcement officers carrying firearms. In its first six months, STAR has responded to 748 incidents, none of which required police or led to arrests or jail time.[78,79]

Officials note that “STAR represents a more empathetic approach to policing that keeps people out of an often-cyclical criminal justice system by connecting people with services like shelter, food aid, counseling, and medication. The program also deliberately cuts down on encounters between uniformed officers and civilians.” The STAR policing alternative empowers behavioral health experts to dictate patient interactions, even when police officers are around, and has been hailed as a success in local Denver communities.[78,79] Many communities around the United States are exploring alternatives to incarceration and law enforcement response to minor incidents.

NATIONAL ASSOCIATION POSITIONS

The American Psychiatric Association (APA) released a position statement in 2020 related to ExD and the use of ketamine. APA does not recognize ExD as a mental disorder and states that the term should not be used until a clear set of diagnostic criteria are validated. APA notes that persons being detained by the police and described as having ExD have frequently received medication

from EMS personnel intended to chemically sedate them, without a medical condition warranting the use of the drug. The APA statement further cautions that chemical sedation medications, including ketamine, used outside of hospital contexts have significant risks, including respiratory suppression. APA also states that an investigation should be undertaken of cases labeled as ExD, that all relevant data be analyzed for disproportionate application of the term, and that all jurisdictions should develop, implement, and routinely update evidence-based protocols for the administration of chemical restraint medications.[80]

The American College of Emergency Physicians (ACEP) recognizes ExD as a medical condition and notes that the exact pathophysiology of ExD remains unidentified.[11,32,81] In articles on the topic, ACEP representatives note that a large component of treating patients is helping law enforcement and EMS recognize possible ExDS patients, and that prehospital ExDS should be presumed if a patient is disoriented or not making sense, constantly physically active, impervious to pain, has superhuman strength, is sweating and breathing rapidly, has tactile hyperthermia, and fails to respond to a police presence. ACEP experts have also advocated that chemical sedation, with ketamine or benzodiazepines, is a first-line treatment.[32,81]

In a 2020 statement, ACEP and the American Society of Anesthesiologists (ASA) discussed the safe use of ketamine in the emergency department and in prehospital care for effective pain management, sedation, the control of delirium in acute psychotic emergencies and drug intoxications. ACEP and ASA noted the dependence on an appropriate medical assessment by a paramedic with medical direction. The statement notes firm opposition to the use of ketamine or any other sedative/hypnotic agent to chemically incapacitate someone solely for a law enforcement purpose and not for a legitimate medical reason.[82]

The American College of Medical Toxicologists (ACMT) hosts educational information related to ExD and ExDS, including definitions, signs and symptoms, and treatment with chemical support/sedation.[83] In a statement released in 2020, ACMT recognized ExD as a condition that warrants consideration of the decision to administer sedating medications. Based on current evidence, ACMT supports the use of sedative and dissociative medications by appropriately trained prehospital paramedical professionals for treatment of severe agitation when other measures have failed, but ACMT does not support the use of these medications solely for the purpose of behavior control on behalf of law enforcement.[84]

In 2020, ACMT, the American Society of Addiction Medicine (ASAM), and the Opioid Response Network (ORN) co-hosted an Addiction Toxicology Case Conference on the topic of intoxication and ExD.[85] The webinar, for continuing medical education credit, featured "discussion of drug-induced agitated delirium with experts dissecting the mechanism and common course of events that occur in the most severe type of agitated delirium, often referred to as Excited Delirium Syndrome. Myths and misperceptions in care of patients with agitation and delirium [were] addressed, as [was] discussion of the appropriate use of sedation..."[83]

The National Association of EMS Physicians (NAEMSP) recognizes that EMS personnel often encounter agitated and combative patients, and these patients frequently require clinical treatment and transportation. A 2016 statement details the NAEMSP position on a several issues related to patient restraint. Notably, NAEMSP believes that EMS agencies should develop scientific protocols for dealing with violent or combative patients, that EMS agencies must assure that all personnel are knowledgeable about the clinical conditions that are associated with agitated or combative behavior and are trained to apply the principles of the system's restraint protocol during patient care. The NAEMSP position statement provides significant details about restraint protocols, notes the use of chemical restraint for ExD, and that chemical restraint, usually with a

butyrophenone, a benzodiazepine, ketamine or other dissociative agents, or a combination of these agents, is an effective and safe method of protecting the violent or combative patient from self-injury. Importantly, the NAEMSP notes that local law enforcement restraint policies/practices may differ from EMS-based restraint protocols, but both agencies should recognize their roles and work cooperatively and proactively to ensure the safe care of patients when application of restraint(s) is necessary.[86]

CONCLUSION

The assessment, diagnosis, and treatment of ExD remains controversial. Despite a lack of scientific evidence, a universally recognized definition, a clear understanding of pathophysiologic mechanisms, or a specific diagnostic test, law enforcement and EMS personnel are taught that ExD is a potentially deadly medical condition – including at time, by physicians. Even deaths attributed to ExD have no consistent anatomical findings, resulting in ExD diagnosis being one of exclusion, defined by epidemiology and the subjective description of a clinical presentation. The individuals most likely to be disproportionately identified as experiencing ExD, and to die from resulting first responder actions, or as a consequence of administration of chemical sedation for a presumed case of ExD, are otherwise healthy Black males in their mid-30s who are viewed as aggressive, impervious to pain, displaying bizarre behavior, and using substances – characterizations that may be based less on evidence and more on generalizations, misconceptions, bias, and racism. Additionally, the identification of ExD has frequently been used in defense cases of law enforcement violence, despite reported autopsy results listing asphyxiation as the cause of death.

While chemical restraint is used in emergency, acute, and psychiatric medical settings to reduce agitation, aggression, or violent behaviors, a rapidly growing movement calls for expanded use of chemical restraint, specifically using ketamine, for several applications, both in and out of the hospital, including for sedation of agitated patients in non-clinical situations and for chemical restraint of persons in law enforcement custody. Police officers and EMS professionals are the most likely first responders to encounter patients perceived to be exhibiting purported ExD. While law enforcement usually evaluates this syndrome, it is usually EMS personnel who provide the sedation, in the “dual response” model.

Reviews of law enforcement agencies and EMS have been called for to evaluate the prevalence of ketamine use in the field in unmonitored individuals and to assess that training and guidelines have been established by supervising medical and behavioral health specialists. Such reviews are appropriate. It is important to assure that de-escalation training be widely implemented, and that personnel are conducting themselves according to guidelines and training to ensure patient safety. New CIT models in which medical and behavioral health specialists, not police, are those first deployed to respond to behavioral emergencies in the community should be encouraged. These models can help assure that decision makers in medical and mental health emergencies who are most appropriate to the circumstances are present with first responders, and that administration of any pharmacological treatments in a non-hospital setting is done equitably, in an evidence-based, stigma-free way.

RECOMMENDATION

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:

1. That the following new AMA policy be adopted:

   Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings
   Our American Medical Association:
   1. Believes that current evidence does not support "excited delirium" or "excited delirium syndrome" as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;

   2. Is concerned about law enforcement officer use of force accompanying "excited delirium" that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces "excited delirium" solely as a justification for the use of force by law enforcement officers.

   3. Opposes the use of sedative/hypnotic agents, including ketamine, to chemically restrain an individual solely for a law enforcement purpose;

   4. Recognizes that drugs for chemical restraint used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;

   5. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
      a. Investigate any cases labeled as "excited delirium" for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
      b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
      c. Assess that training and guidelines have been properly established by supervising medical and behavioral health specialists, are appropriate, and include de-escalation training; and
      d. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training to ensure patient safety; and

   6. Urges law enforcement and emergency medical service personnel to participate in appropriate training that minimally includes de-escalation techniques and the appropriate use of drugs used to restrain individuals; and

   7. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in a non-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way.
   (New HOD Policy)

2. That Policy H-65.954, "Policing Reform," which recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA's willingness to work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers, states that AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures, and will advocate for legislation and regulations which promote trauma-informed, community-based safety practices, be reaffirmed. (Reaffirm Current AMA Policy)

3. That Policy H-345.972, "Mental Health Crisis Interventions," which supports jail diversion and community based treatment options for mental illness, implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, federal funding to encourage increased community and law enforcement participation in crisis intervention training programs, and legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities, be reaffirmed. (Reaffirm Current AMA Policy)

Fiscal Note: Less than $1000

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(JUN-21)

Introduced by: New York

Subject: Ensuring Correct Drug Dispensing

Referred to: Reference Committee E

Whereas, Medication errors affect millions of people every year with the clinical and economic consequences of those errors having been widely documented; and

Whereas, Much is known about hospital medication errors because of their well-established reporting systems for continuous monitoring; and

Whereas, In a hospital a dispensing error can be detected and prevented by nursing personnel at the administration stage; and

Whereas, *The New York Times* published an article entitled "*How Chaos at Chain Pharmacies Is Putting Patients at Risk"* which stated that pharmacists at companies such as CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces which made it difficult to perform their jobs safely and can lead to "dispensing errors"; and

Whereas, Currently, in some states, any drug dispensed must bear a label on its container which identifies the name and address of the owner of the establishment in which it was dispensed, the date compounded, the number of the prescription under which it is recorded in the pharmacist's prescription files, the name of the prescriber, the name and address of the patient, and the directions for the use of the drug by the patient as given upon the prescription; and

Whereas, When a prescription is filled in a retail pharmacy, the last checkpoint for safety is the patient or caregiver who may not have the training and knowledge to know that the dispensed drug is actually the medication prescribed; therefore be it

RESOLVED, That our American Medical Association request that the United States Food and Drug Administration work with the pharmaceutical and pharmacy industries to facilitate the ability of pharmacies to ensure that a color photo of a prescribed medication and its dosage is attached to the sales receipt to ensure that the drug dispensed is that which has been prescribed. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/31/21

AUTHOR'S STATEMENT OF PRIORITY

Providing a color photo of a dispensed pharmaceutical would reduce the number of drug dispensing errors made by pharmacies and hospital dispensaries. It would also help patients to be sure what they are taking is the correct drug. Providing as much information as possible at each step in the dispensing process would reduce the number of errors made each year. More information about a patient's medications can only help everyone in the chain of medication use. The sooner this is implemented the sooner mistakes are eliminated.

RELEVANT AMA POLICY

Epidemiology of Drug Errors H-120.963
The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors.
Citation: Sub. Res. 519, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Supporting Safe Medical Products as a Priority Public Health Initiative H-120.958
Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; and (5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.
Citation: Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10; Modified: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(JUN-21)

Introduced by: New York

Subject: Scientific Studies which Support Legislative Agendas

Referred to: Reference Committee E

Whereas, An important tool in advancing an organization's agenda is the ability to produce scientific or economic studies as evidence for supporting such a position; and

Whereas, An important tool in advancing an organization's agenda is collaborating with diverse groups who together can present a unified perspective on a particular issue; and

Whereas, The AMA regularly works with numerous and varied organizations to build allies and obtain research data in support of its efforts to achieve its key public health and legislative goals; and

Whereas, The goals of organized medicine and allied organizations include advocacy on behalf of patients and public health in addition to physicians; and

Whereas, Advocacy supported by scientific and economic information carries more weight and benefits those advocacy efforts; and

Whereas, Opponents of the policy goals of organized medicine often have the capacity to produce such studies; and

Whereas, The recent debate before Congress to address surprise medical bills often found physician organizations at odds with the perspectives of not only the insurance industry, but also the business, labor, and patient advocacy organizations as well as numerous think thanks; and

Whereas, This debate reiterated the importance of developing allies and research data to help work to achieve these public health and legislative goals; therefore be it

RESOLVED, That our American Medical Association continue and expand its efforts to work with allied groups, health care policy influencers such as think tanks, and entities that can produce high quality scientific evidence, to help generate support for the AMA's key advocacy goals. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 03/31/21

AUTHOR'S STATEMENT OF PRIORITY

AMA works with many groups toward shared goals, this resolution seeks to expand that network to ensure that medicine, and healthcare for patients is seen as a top priority for all stakeholders. Always important, alliances within healthcare have taken on increased urgency as outside influences, groups and government erode physician autonomy, practice income, and patient care. During the past year, the value of scientifically accurate information has been brought to the forefront of the public eye through the media and agencies such as the CDC. AMA needs to strengthen and expand its network of allies and contacts so that undisputed scientific information can be provided/utilized to support AMA advocacy goals, physicians, patients and continued excellence in US healthcare.

RELEVANT AMA POLICY

Statement of Collaborative Intent G-620.030
(1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine;
(b) work for the common good of all patients and physicians;
(c) promote trust and cooperation among members of the Federation; and
(d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians.
(2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent: (a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians.
(b) Organizations in the Federation will be supportive of membership at all levels of the Federation.
(c) Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.
(d) Each organization in the Federation of Medicine will actively participate in the policy development process of the House of Delegates.
(e) Organizations in the Federation have a right to express their policy positions.
(f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
(g) Organizations in the Federation will support an environment of mutual trust and respect.
(h) Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.
(i) Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations.
(j) Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them.
(CLRPD/CEJA/C&B Report, A-97; Consolidated: CLRPD Rep. 3, I-01; Modified: BOT Rep. 23, A-02; Modified: CCB/CLRPD Rep. 3, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(JUN-21)

Introduced by: American Society of Addiction Medicine

Subject: Access to Evidence-Based Addiction Treatment in Correctional Facilities

Referred to: Reference Committee E

Whereas, Provisional data indicate drug overdose deaths exceeded 90,000 during the 12 months ending in September 2020,[1] the highest number of overdose deaths ever recorded during a 12-month period; and

Whereas, Opioid overdose death rates are increasing more rapidly among Black Americans than white Americans;[2] and

Whereas, Experts attribute the acceleration in drug overdose deaths to the disruption to daily life due to the COVID-19 pandemic;[3] and

Whereas, Scholars have noted early indicators that the pandemic is increasing racial inequities in overdose deaths;[4] and

Whereas, Incarcerated individuals are 129 times more likely to die from overdose within the first two weeks after release when compared to the general U.S. population[5] and nearly five percent of all deaths from illicit opioids occurs among people who were released from jail or prison in the past month;[6] and

Whereas, Black adults are 5.9 times as likely to be incarcerated than whites and Hispanics are 3.1 times as likely to be incarcerated as whites;[7] and

Whereas, Effective substance use disorder treatment, including medications, is key to preventing relapse, overdose and death;[8] and

Whereas, Individuals who are receiving medications for the treatment of opioid use disorder (OUD) prior to incarceration may be forced to discontinue such treatment, and those with untreated OUD are often not offered evidence-based and life-saving treatment upon entering jail[9] or prison;[10] and

Whereas, Federal Medicaid funds are prohibited by law from being used for health care in jails and prisons ("the inmate exclusion clause" of the 1965 Social Security Act), and law generally prevents payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered; and

Whereas, Our AMA has endorsed the use of medications for OUD in prisons, encouraged public funding for such programs, and supported the establishment of post-incarceration programs to continue OUD; therefore be it

RESOLVED, That our American Medical Association amend policy H-430.987, "Opiate Replacement Therapy Programs in Correctional Facilities," by addition and deletion to read as follows:

~~Opiate Replacement Therapy Programs~~ Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement therapy (ORT)~~ medications for opioid use disorder (OUD) as ~~an effective therapy in treating opiate-addicted~~ the standard of care for persons with OUD who are incarcerated; and (b) ~~ORT for opiate-addicted~~ medications for persons with OUD who are incarcerated, an endorsement in collaboration with ~~the National Commission on Correctional Health Care and~~ the American Society of Addiction Medicine.

2. Our AMA advocates for legislation, standards, policies and funding that ~~encourage~~ require correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use disorder~~, including initiation and continuation of ~~opioid replacement therapy~~ medications for OUD, in conjunction with ~~counseling~~ psychosocial treatment when available and desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting.

3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, including medications for addiction treatment ~~medication assisted therapy~~.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-430.986, "Health Care While Incarcerated," by addition and deletion to read as follows:

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA ~~urges~~ advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.~~, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.~~
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8.~~7~~. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of ~~incarcerated~~ women and adolescent females who are incarcerated, including gynecological care and obstetrics care for ~~pregnant and postpartum~~ ~~women~~ individuals who are pregnant or postpartum.
9.~~8~~. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both ~~inmates~~ individuals who are incarcerated and staff in correctional facilities.
10.~~9~~. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/04/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has highlighted and exacerbated the stark racial health disparities that exist in the United States, with Black and Latinx Americans experiencing worse health outcomes than white Americans. At the same time, the pandemic has accelerated the epidemic of drug overdose deaths. Record numbers of drug overdose deaths are being projected for 2020, with overdose death rates increasing more rapidly among Black Americans than whites.

Patients' involvement with the criminal legal system complicates the medical community's efforts to treat addiction, prevent overdose deaths, and reduce health disparities related to substance use. For decades, America has tried to arrest and incarcerate away problems with drug use and addiction rather than treat addiction as a medical disease. As a result, millions of individuals with a preventable and treatable medical disease – many of them Black and Latinx Americans, who are incarcerated at much higher rates than whites despite similar rates of drug use – have been locked up where they have not been offered evidence-based treatment for their disease. Upon their release, they are 129 times more likely to die from overdose than the general population.

Access to opioid use disorder (OUD) treatment, including all FDA-approved medications for OUD, in jails and prisons is a critical public health and ethical issue. Our AMA must take a leadership role in calling for evidence-based, medical treatment for the nearly 20 percent of individuals who are incarcerated who meet criteria for OUD.

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RELEVANT AMA POLICY

Opiate Replacement Therapy Programs in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) as an effective therapy in treating opiate-addicted persons who are incarcerated; and (b) ORT for opiate-addicted persons who are incarcerated, in collaboration with the National Commission on Correctional Health Care and the American Society of Addiction Medicine.
2. Our AMA advocates for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy in conjunction with

counseling, in correctional facilities within the United States and that this apply to all incarcerated individuals including pregnant women.
3. Our AMA supports legislation, standards, policies, and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including pregnant women, are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths and help ensure post-incarceration medical coverage and accessibility to medication assisted therapy.
Citation: Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(JUN-21)

Introduced by: Delaware

Subject: Healthy Air Quality

Referred to: Reference Committee E

Whereas, Particulate matter (PM) or particle pollution is a mixture of solid particles and liquid droplets found in the air that come in many sizes and shapes and can be made up of hundreds of different chemicals[1]; and

Whereas, Particulate matter inhaled can get deep into the lungs and even into the bloodstream[1]; and

Whereas, Particles less than 2.5 micrometers in diameter, also known as fine particles or PM 2.5, pose the greatest risk to health[1]; and

Whereas, In 2016-2018, more cities had high days of ozone and short-term particle pollution compared to 2015-2017 and many cities measured increased levels of year-round particle pollution[2]; and

Whereas, Harmful revisions and setbacks to key protections currently in place or required under the Clean Air Act of 1970 threaten to make air quality even worse in parts of the US[2]; and

Whereas, Atmospheric pollutants have been linked to a host of chronic and acute illnesses, and contribute to the risk of COVID-19 complications, with preventable health, social, and economic impacts[3-8]; and

Whereas, Evidence that both prenatal and postnatal exposures to PM 2.5 are associated with later development of allergic rhinitis, a precursor to pediatric asthma, the vulnerable time window may be within late gestation and the first year of life[8]; and

Whereas, Poor air and water quality disproportionately affect the economically disadvantaged as well as communities of color[3-5,7-9]; and

Whereas, Statistics for 2020 show the nation's electricity was generated from 60% of fossil fuels, 20% from nuclear supplies and another 20% from renewable sources[10]; and

Whereas, Current technology is capable of replacing fossil fuel-generated power with renewable sources[7,11]; therefore be it

RESOLVED, That our American Medical Association champion legislation and policies at the federal level to shift our energy generation away from polluting sources like fossil fuels and toward less polluting renewables in order to drive down the generation of PM 2.5 and other pollutants. (Directive to Take Action)

1

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Air pollution is the leading environmental health risk humans face. The combined effects of outdoor and household air pollution cause around seven million (one in eight) premature deaths every year, largely as a result of increased mortality from stroke, heart disease, lung disease, and cancers.

According to data from the World Health Organization (WHO), air quality in most cities fails to meet WHO guidelines for safe levels, putting people at additional risk of respiratory disease and other health problems. Without action, air pollution in many cities will continue to get worse.

Emerging research is shedding light on the links between air pollution and severe illness from COVID-19, underscoring the critical need to ensure healthy air for all. Researchers SUNY College of Environmental Science and Forestry found that an increase in exposure to hazardous air pollutants is associated with a 9% increase in death among patients with COVID-19, after accounting for differences in wealth and other health issues. Another study from the Harvard T.H. Chan School of Public Health and the Dana-Farber Cancer Institute looked at the impact of long-term exposure to fine particle pollution on COVID-19 death rates. Researchers found that just a small increase (1 microgram per cubic meter) in long-term average exposure to fine particle pollution is associated with an 11% increase in the COVID-19 death rate. Adding to the evidence on the connection between racial disparities, air pollution, and COVID-19, the researchers found a 49% increase in the COVID-19 death rate in counties with elevated fine particle pollution and that had a higher Black population.

While the COVID-19 pandemic is understandably treated as an imminent danger, the climate crisis is thought of as a consequence yet to come and that will be dealt with in the future.

The Medical Society of Delaware requests that our resolution, "Healthy Air Quality," be considered an urgent priority resolution for the upcoming Special Meeting of the AMA House of Delegates in June 2021 for these reasons. There is support from the Biden Administration to confront the climate crisis, to include protecting the air from harmful pollution. The time is now to make important changes for the health of our patients.

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RELEVANT AMA POLICY

Preventing Death and Disability Due to Particulate Matter Produced by Automobiles H-135.915
Our AMA will: (1) promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation; and (2) support individual states' legal efforts to retain authority to set vehicle tailpipe emission standards that are more stringent than federal standards.
Citation: Res. 915, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
Citation: BOT Rep. 34, A-18

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2.Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.
Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Protective NAAQS Standard for Fine Particulate Matter (PM 2.5) H-135.946
Our AMA supports more stringent air quality standards for particulate matter. We specifically request a NAAQS that provides improved protection for our patients which includes:
- 12 µg/m3 for the average annual standard
- 25 µg/m3 for the 24-hour standard
- 99th percentile used for compliance determination.
Citation: BOT Action in response to referred for decision Res. 720, I-05; Reaffirmed in lieu of Res. 507, A-09; Modified: CSAPH Rep. 01, A-19

Protective NAAQS Standard for Particulate Matter (PM 2.5 & PM 10) D-135.978
At such time as a new EPA Proposed Rule on National Ambient Air Quality Standards for Particulate Matter is published, our AMA will review the proposal and be prepared to offer its support for comments developed by the American Thoracic Society and its sister organizations.
Citation: BOT action in response to referred for decision Res. 926, I-10; Reaffirmed: Res. 915, I-19;

Support the Health Based Provisions of the Clean Air Act H-135.950
Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.
Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11)

Environmental Preservation H-135.972
It is the policy of the AMA to support state society environmental activities by:
(1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
(2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
(3) maintaining a global perspective on environmental problems;
(4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
(5) encouraging state and component societies that have not already done so to create environmental committees.
Citation: Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Clean Air H-135.979
Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.
Citation: Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports

enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

Global Climate Change - The "Greenhouse Effect" H-135.977
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) encourages humanitarian measures to limit the burgeoning increase in world population.
Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

Federal Clean Air Legislation H-135.984
1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.
2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA’s Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act.
Citation: Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 917, I-18

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.
Citation: (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14)

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.
Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Reducing Sources of Diesel Exhaust D-135.996
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPAs proposal to roll back the glider Kit Rulewhich would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.
Citation: Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14; Modified: Res. 521, A-18

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19;

AMA Position on Air Pollution H-135.998
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.
Citation: BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(JUN-21)

Introduced by: Pennsylvania

Subject: Personal Care Products Safety

Referred to: Reference Committee E

Whereas, The Federal Food, Drug, and Cosmetic (FD&C) Act that is designed to ensure the safety of personal care products, referred to as “cosmetics” – including makeup, fragrance, lotion, toothpaste, body wash, shampoo, deodorant and more – has remained largely unchanged since the law was enacted in 1938; [1] and

Whereas, FDA can pursue enforcement action against products on the market that are "adulterated" or "misbranded" and against firms or individuals who violate the law, manufacturers are not required to register in the Voluntary Cosmetic Registration Program and FDA estimates that only one-third of firms file cosmetic product ingredient statements; [2] and

Whereas, Although companies and individuals who manufacture or market cosmetics have a legal responsibility to ensure the safety of their products, and the Cosmetic Ingredient Review (CIR) Expert Panel that includes dermatologists, pathologists, toxicologists, and chemists set standards for components of cosmetics, there are currently no legal requirements for cosmetic manufacturers who market products to American consumers to test their products for safety; [1, 3] and

Whereas, FDA lacks authority to issue mandatory recalls of products based on safety concerns and can only warn consumers about contaminated products; and cosmetic firms are not required to initiate recalls when FDA becomes aware of adulterated or misbranded cosmetic products on the market; [2] and

Whereas, Cosmetic firms are not required to provide any safety information to FDA even if requested by FDA during an inspection; [2] and

Whereas, States may have more extensive requirements for cosmetic manufacturers, distributors, and packagers than exist federally, [4] while a nationwide standard would enable more uniform regulatory oversight; and

Whereas, FDA regulatory oversight authority is limited and FDA faces challenges in identifying and analyzing safety signals due to its lack of reliable and complete serious adverse event report data; [2] and

Whereas, Firms are not required to follow FDA draft guidance on good manufacturing practices (GMPs) for cosmetics products; [2] and

Whereas, The program for cosmetics at the Center for Food Safety and Applied Nutrition, FDA’s lead Center for the regulation of cosmetics, was approximately $10 million or about three percent of the Center’s budget, despite 2,727,847 lines of cosmetics products imported into the

United States from 177 countries in FY 2018, an increase of more than one million lines of annual cosmetic imports since one decade prior; [2] and

Whereas, Based on different regulatory frameworks, there are few restrictions on materials that a cosmetic manufacturer may use as a cosmetic ingredient without premarket approval from FDA, [2, 5, 6] where the United States prohibits or restricts 11 types of harmful ingredients from cosmetics, while the European Union has banned or restricted more than 1,300 chemicals [7] often due to absence of safety data rather than data that shows harm; [8] and

Whereas, Decisions should be evidence-based; 595 cosmetic manufacturers have reported using 88 chemicals that have been linked to cancer, birth defects or reproductive harm in more than 73,000 products since 2009, [4, 9] however, FDA has testified that most cosmetics on the market in the United States are safe and in rare cases when safety issues arise many firms work with FDA to address them; [2] in addition a causative relationship between endocrine disruption and cancer and the concentration of certain ingredients in cosmetic products "has not been proven scientifically;" [10, 11] and

Whereas, Chemical use and concentration should be considered; researchers found that permanent hair dye and straighteners were associated with an increased risk for breast cancer [12, 13] and formaldehyde found in hair products can expose salon workers to health risks, [14,] however, parabens and formaldehyde releasers prevent severe infections and complications such as the *Pseudomonas*-induced corneal ulcers from inadequately preserved mascara; [15, 16] and

Whereas, FDA confirmed the presence of asbestos in makeup products sold by two different retail stores, [17, 18, 19, 20] and asbestos exposure is associated with mesothelioma and cancers of the lung, larynx, and ovary; and linked to increased risks of cancers of the stomach, pharynx, and colorectum; [21] and

Whereas, FDA discovered elevated lead levels in a bentonite clay product sold online and in retail outlets, and lead poisoning can lead to anemia, weakness, kidney and brain damage, and death; and pregnant women who are exposed to lead will also expose their unborn child, which can cause potentially serious health complications; [22, 23] and

Whereas, Restrictions should be evidence based; for example, propyl paraben is used in a wide range of products, a finding of questionable significance in a topically applied personal care product since parabens are poorly absorbed percutaneously, [10] studies have shown that some parabens injected in very high doses were found to be thousands to millions of times weaker than estradiol in rats and yeast cells, [11, 24] a study that claimed to find parabens in human breast tumors lacked a control group and parabens were found in blank samples, [11, 25] and the CIR extensively reviewed the scientific literature on paraben safety and concluded that the parabens as currently used in personal care products in the United States are safe; [10] and

Whereas, AMA policy H-440.855 supports that FDA should be able to recall cosmetic products that it deems to be harmful and supports creation of a publicly available registry, however, the registry remains voluntary with limited participation by manufacturers; therefore be it

RESOLVED, That our American Medical Association advocate that the Food and Drug Administration (FDA) be given the appropriate resources and authority to effectively regulate and enforce standards for personal care products, including being authorized to mandate registration and reporting by manufacturers, conduct appropriate inspections of manufacturing facilities, ensure robust review of product safety, and require adherence with Good Manufacturing Practices while allowing flexibility for small business to comply; and reaffirm support for providing the FDA with sufficient authority to recall cosmetic products that it deems to be harmful. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The Pennsylvania Delegation would appreciate the committee considering its Resolution A-20, "Personal Care Products Safety," to be "High Priority" for the upcoming June HOD. Safety concerning products in personal cosmetics sold to American consumers is of utmost importance to both those who use them, and their physicians, who are responsible for the health and safety to some degree of all patients. Federal law designed to make sure laws are safe in this regard have not changed since 1938. Over time, only 11 chemicals identified in American cosmetics have been banned, as opposed to more than 1,300 in Europe. Clearly, we are way behind in providing safe cosmetics for American citizens. The personal care products needing safety scrutiny include hair, lotion, makeup, toothpaste, shampoo, deodorant, body wash and fragrance – all staples of use by millions of people in our country. Known carcinogenic chemicals previously identified in cosmetics include asbestos, hair dye and hair straighteners; lead, propyl paraben and formaldehyde are others with known adverse health effects that have been identified. Clearly, this is a public health hazard of extreme proportions that can be begun to be addressed by introducing new bipartisan legislation that requires the FDA to evaluate a minimum of 5 ingredients found in personal care products sold in the U.S. It behooves the AMA to take the lead in investigating the scope and extent of possible harm and injury of personal care safety products to U.S. consumers, who are all our patients.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(JUN-21)

Introduced by: Pennsylvania

Subject: Wireless Devices and Cell Tower Health and Safety

Referred to: Reference Committee E

Whereas, Industry propaganda is masking and mitigating the scientific evidence showing concerning biological effect to pulsated microwave and millimeter wave electromagnetic fields (EMF), the type of radiation emitted from all of our wireless devises (cell phones, cell phone towers, WiFi, computers, smart TV, smart meters, bluetooth, etc); and

Whereas, Most citizens are under the false impression that there are bonafide safety guidelines set forth by the FCC. The safety guidelines, established in 1996 under the leadership of telecommunications lobbyist Tom Wheeler, are ONLY based on an erroneous assumption that microwaves are dangerous when they heat liquids up (so-called “thermal” EMF), much like a microwave oven; and

Whereas, Now there is overwhelming scientific evidence that non-thermal EMFs can cause significant health effects at levels that are orders of magnitudes lower than those allowed by these FCC guidelines; and

Whereas, The data shows that fetuses and children are far more vulnerable to these effects, as they have higher surface to volume ratios, high densities of stem cells, a developing brain, and tissue with greater extracellular water leading to deeper penetration effects; and

Whereas, Based on the 1996 Telecommunications Act, local jurisdictions do not have the right to approve or disapprove the placement of cell tower based on safety or health reasons. In the last two years, Verizon and AT&T have tried twice to convince the PA General Assembly to approve a bill that further preempts municipal rights for managing 5G cell towers in the public rights-of-way; therefore be it

RESOLVED, That our American Medical Association oppose legislation that blocks the public's right to guard its own safety and health regarding cell tower placement (Directive to Take Action); and be it further

RESOLVED, That our AMA promote ways to reduce radiation exposure from wireless devices, especially for pregnant women and children (wired devices preferable to wireless, shielding, etc.). (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

With the pervasiveness of wireless communication in our present-day society, the resolution is concerned with the possible effects of EMF (electromagnetic field) on humans, particularly the more vulnerable such as children and fetuses.

It is felt that the standards for such safety, established in 1996, were biased by lobbyist, and exclusive of other scientific criteria. Furthermore, the telecommunications act of 1996 usurps local jurisdiction on the placement of telecommunication towers.

It is therefore requested that our AMA oppose legislation that may block the public's "access to know" in these matters and foster shielding of EMF effects from wireless devices.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(JUN-21)

Introduced by: Colorado, American Academy of Ophthalmology, GLMA: Health Professionals Advancing LGBTQ Equality, American Society of Cataract and Refractive Surgery

Subject: Evidence-Based Deferral Periods for MSM Donors of Blood, Corneas and Other Tissues

Referred to: Reference Committee E

Whereas, On May 20, 1994, the US Public Health Service instituted a policy prohibiting donation of corneas and other tissues by "[men] who have had sex with another man [MSM] in the preceding 5 years" even if all required infectious disease testing is negative,[1] a policy which continues to be enforced today by the US Food and Drug Administration (FDA)[2]; and

Whereas, The 5-year MSM deferral policy was instituted at a time when HIV tests were unreliable and has not been updated to reflect advances in HIV testing since 1994[3,4]; and

Whereas, All corneal donors are required to undergo HIV testing, which is now reliable within 4-8 days of viral exposure[5,6]; and

Whereas, No case of HIV transmission from a corneal transplant has ever been reported, even in cases when the corneal donors were HIV-positive[3,7,8,9,10,11]; and

Whereas, Corneas are an avascular tissue and are not a major reservoir of HIV[12]; and

Whereas, Current FDA policy treats MSM corneal donors more strictly than other potentially high-risk donors (e.g. while MSM donors must be abstinent for 5 years, heterosexual donors in a sexual relationship with someone known to be HIV-positive are only ineligible for 1 year after last sexual contact with an HIV-positive individual)[2]; and

Whereas, MSM blood donors are only ineligible for 3 months after last sexual contact, despite the known risk of HIV transmission through blood transfusions[13]; and there is no deferral period whatsoever for MSM donors of solid organs (such as hearts, lungs, kidneys, etc.)[14,15]; and

Whereas, Many peer nations have no deferral period for MSM corneal donors whatsoever (e.g. Spain,[16] Italy,[17] Mexico,[18] Chile,[19] Argentina,[20] Germany,[21] Denmark,[22] South Africa[23]); and

Whereas, Many other peer nations have deferral periods for MSM corneal donors far shorter than 5 years (e.g. 3 months in the United Kingdom,[24] 4 months in the Netherlands,[25] 4 months in France,[26] 12 months in Canada[27]); and

Whereas, AMA Policy H-50.973, "Blood Donor Deferral Criteria," states that AMA supports blood donor deferral criteria that are "representative of current HIV testing technology" but does not address the FDA's even stricter deferral criteria for MSM donors of corneas and other tissues[28]; and

Whereas, A recent *JAMA Ophthalmology* study estimated that between 1558 and 3217 potential corneal donations were disqualified in 2018 alone in the United States and Canada due to the two countries' bans on MSM corneal donors[3]; and

Whereas, An estimated 12.7 million visually impaired patients are in need of corneal transplant surgery worldwide, with only 1 cornea donated for every 70 corneal transplants needed[29]; therefore be it

RESOLVED, That our American Medical Association amend current policy H-50.973, "Blood Donor Deferral Criteria," by addition and deletion as follows:

> Blood and Tissue Donor Deferral Criteria
> Our AMA: (1) supports the use of rational, scientifically-based ~~blood and tissue donation~~ deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood and tissue donation (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM donors of corneas and other tissues. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We believe this resolution meets all the criteria to be classified as "High Priority."
Corneal transplantation is the most commonly performed transplant surgery in the United States, yet there is only 1 cornea donated for every 70 corneal transplants needed worldwide. A recent *JAMA Ophthalmology* study estimated that up to 3217 blind patients a year are deprived of vision-restoring surgery due to outdated FDA policy banning corneal donation by men who have had sex with another man in the preceding 5 years, even if all infectious disease testing is negative.
AMA has spoken clearly and repeatedly to advocate for evidence-based guidelines for MSM *blood* donation, yet AMA has never previously advocated for changes to the FDA's separate policies preventing MSM donation of corneas and other tissues. This represents a substantial gap in AMA policy. Arguing for evidence-based health policy and for equitable treatment of the LGBTQ community is consistent with AMA's mission and existing policy.
Since the FDA's policy for MSM corneal donors is classified as *regulatory guidance* and not as an official regulation, the FDA could change its stance on this issue through a simple press release, without requiring an act of Congress or a formal "notice and comment" process. The relative bureaucratic ease of this change means that there is a realistic chance that AMA advocacy could convince the FDA to act. Any further delay would continue to deprive thousands of blind patients of vision-restoring surgery, while allowing an inequitable health policy against the LGBTQ community to endure.

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Reference Committee F

BOT Report(s)

01 Annual Report

03 AMA 2022 Dues

12 Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment

Joint Report(s)

01* CCB/CLRPD Joint Council Sunset Review of 2011 House Policies

Resolution(s)

601* $100 Member Annual Dues Payment Through 2023

602* Timely Promotion and Assistance in Advance Care Planning and Advance Directives

603* AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels

604* Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

605* Amending G-630.140, Lodging, Meeting Venues and Social Functions

606* AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations

** Contained in the Handbook Addendum*

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-JUN-2021

Subject: Annual Report

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee F

The Consolidated Financial Statements for the years ended December 31, 2020 and 2019 and the Independent Auditor's report have been included in a separate booklet, titled "2020 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

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2020

AMA ANNUAL REPORT

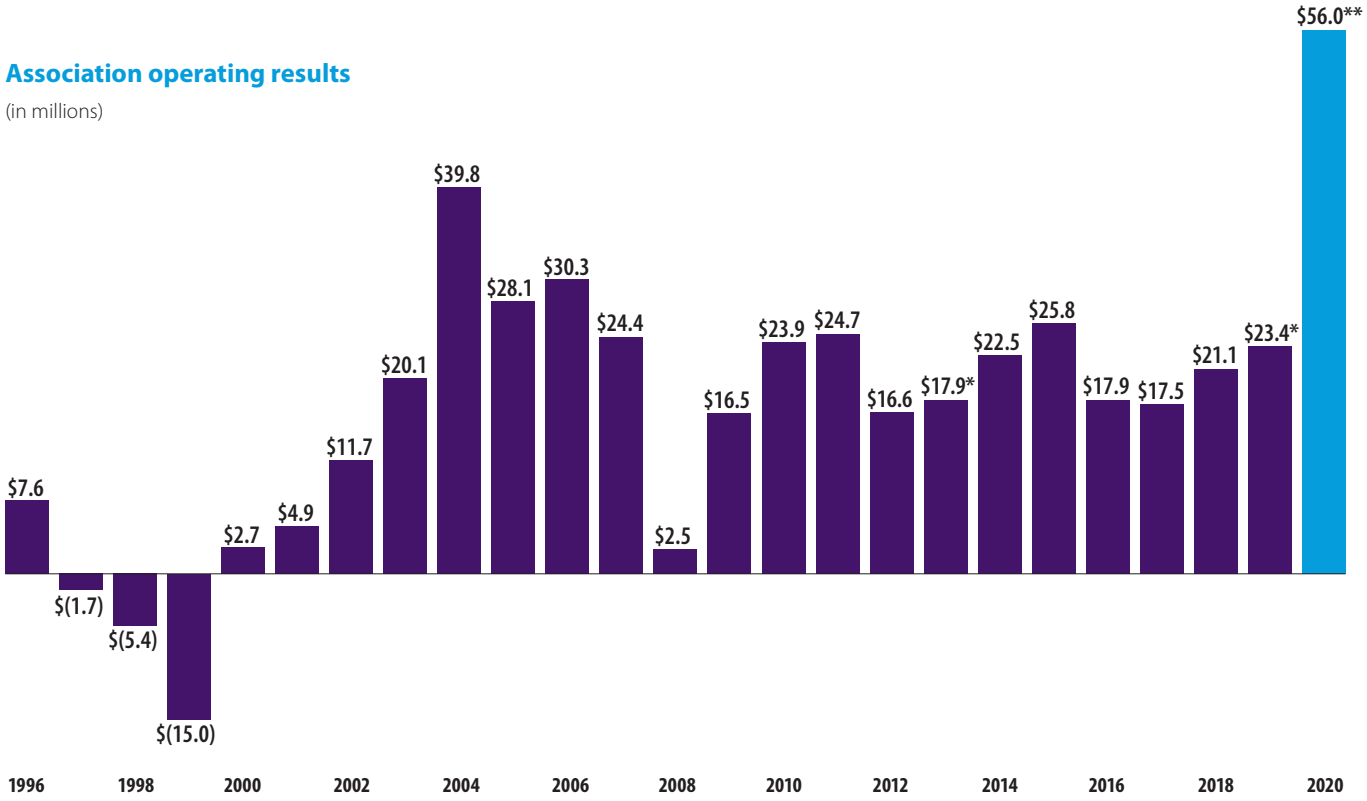
Financial highlights

(Dollars in millions)	2020	2019
Revenues	$ 433.4	$ 392.3
Cost of products sold and selling expense	29.3	27.8
General and administrative expenses, excluding pension termination expense	342.1	335.3
Pro forma operating results*	56.0	23.4
Pension termination expense	-	(36.2)
Non-operating items	58.6	75.2
Defined benefit postretirement plan non-service periodic expense	(2.5)	(3.9)
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	(2.8)	17.0
Change in unrestricted equity	109.3	75.5
Change in donor restricted equity	(1.5)	(0.1)
Change in association equity	$107.8	$75.4
Association equity at year-end	$732.0	$624.2
Employees at year-end	1,215	1,146

**Excluding $36.2 million in noncash pension termination expense reclassified from non-operating expense in 2019*

Association operating results

(in millions)



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

***2020 results were impacted by a freeze in hiring and cancellation of all travel and meetings during the year due to the pandemic. These savings are temporary in nature.*

Letter to stakeholders

In a year defined by disruption and loss, America's physicians and health care professionals at every level rose to the immense challenge of COVID-19 at great personal risk to themselves and their families.

Every step of the way, the American Medical Association proved to be an ally to physicians and to patients in this historic moment, giving voice to their needs and supporting them by:

- Providing clear guidance and trusted, evidence-based resources for physicians on the front lines
- Helping medical practices recover from the damage of the pandemic
- Pushing the government to reduce and remove obstacles to patient care
- Urgently advocating for science-based, equitable policies on pandemic control strategies, testing and vaccine development and distribution

A year of unprecedented challenges and unprecedented AMA-driven results

The AMA's federal advocacy efforts helped secure billions in emergency funding for physician practices to help them weather the economic storm of COVID-19 and continue to provide critical care to patients. We achieved broad telehealth expansion across the United States, and created tools and resources to make it easier to integrate remote care into independent practices—an important advancement that provided a critical lifeline for chronically ill patients and their physicians as shelter-in-place requirements became the norm.

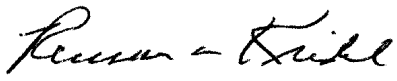
The AMA grew its digital platform to meet the surging informational needs of physicians during the pandemic with expanded livestreams, podcasts, daily COVID-19 updates, and curated resources and research from across the AMA and its JAMA Network™. Engagement metrics rose dramatically across all AMA platforms in 2020 as physicians sought credible, science-based information about the novel coronavirus as misinformation and politicization overwhelmed the early stages of the pandemic.

AMA leaders helped drive a national conversation about the importance of science and evidence in guiding our response to COVID-19 and provided much-needed clarity about the vaccine development process in 115 national media interviews, hundreds of virtual conferences and events, physician-focused townhalls and webinars, and dozens of op-eds and editorials. This exposure contributed to a record 115 billion media impressions in 2020.

Our "Prioritizing Equity" web series, led by the AMA Center for Health Equity, illuminated the devastating effects of the virus on Black, Latinx and Indigenous communities and provided a deeper understanding of systemic racism's lasting impact on public health.

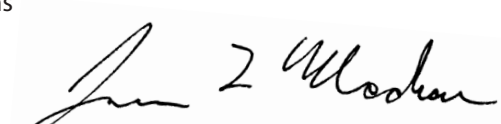
The many ways the AMA supported physicians in 2020 contributed to another strong financial performance and a 6 percent increase in membership, our 10th consecutive year of growth.

During an incredibly difficult year, the AMA's unprecedented response to COVID-19 brought the meaning of our work into sharp focus, and a recommitment and recalibration of our priorities for the road ahead. To be the physicians' powerful ally in patient care is to always fight on the side of science, equity and improving public health. This is a challenge we proudly accept.

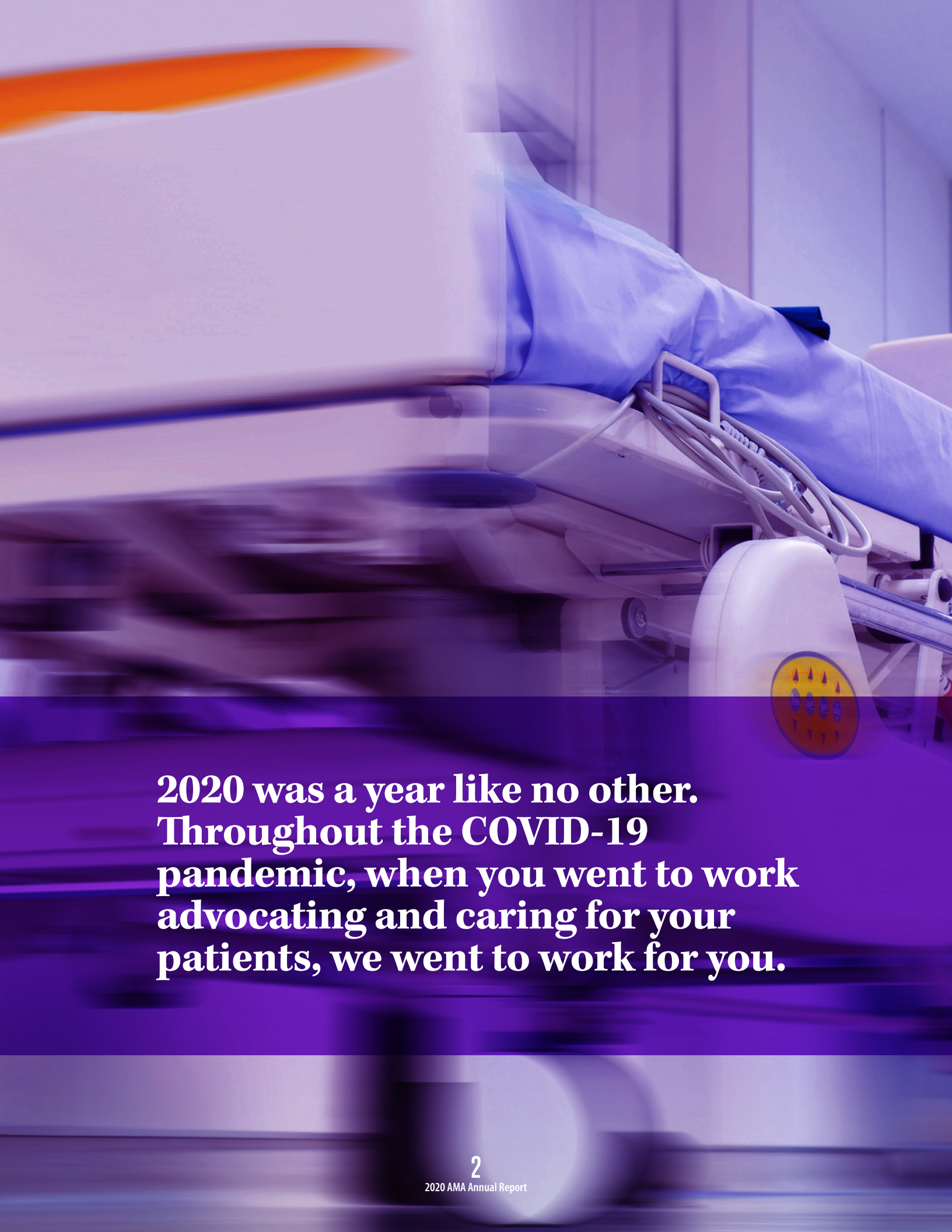


Russ Kridel, MD
Chair, Board of Trustees

Scott Ferguson, MD
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President



2020 was a year like no other. Throughout the COVID-19 pandemic, when you went to work advocating and caring for your patients, we went to work for you.

When COVID-19 seemed a distant threat, we built a definitive online resource to help you diagnose, prevent and treat the virus. When you didn't have the PPE you needed, we pushed the administration to produce more. When your practices were threatened financially, we helped secure funding. And when the nation was faced with misinformation, we led the fight for science and data—keeping the faces and voices of physicians front and center.

Anna Yap, MD
Emergency medicine

Providing resources and guidance to physicians

Building on our **strategic efforts to advance telehealth and improve physician well-being and practice sustainability** during the pandemic, the AMA helped foster widespread adoption of remote patient care through The Telehealth Initiative, the Telehealth Implementation Playbook and accompanying resource guide. We also created dozens of free, online resources to help physicians better manage their mental health and keep their practices afloat.

The AMA worked closely with the White House, Congress, state lawmakers and a range of federal and state agencies to ease the public health and economic consequences of COVID-19. We **secured billions in emergency funding for physician practices** and obtained a broad expansion of telehealth services and payment.

The AMA **launched a physician-focused webinar series with federal health officials** that explored the COVID-19 vaccine development process and rollout. We also launched a comprehensive campaign across multiple platforms and channels, including media interviews, to build confidence in the safety and efficacy of the new vaccines among physicians, health care professionals and the public.

The AMA responded to dire shortages of personal protective equipment by **helping secure hundreds of thousands of PPE units** for AMA physician members through a creative new collaboration with Project N95, a non-profit national clearinghouse for medical supplies.

The Current Procedural Terminology Panel **issued 24 new or revised CPT® codes supporting COVID-19 care**, guides and tools that were the most-downloaded documents from the AMA COVID-19 Resource Center.

The AMA COVID-19 Resource Center was a **trusted source for clear, evidence-based guidance** throughout the year. Features included daily video updates, action plans, quick-start telehealth guides, care for caregivers and more.

The JAMA Network provided access to a wealth of **scientific resources on COVID-19 diagnosis and treatment**, with a focus on information physicians could share with patients and their families. Expanded livestream and podcast portfolios contributed to a 40 percent surge in online traffic across the JAMA Network in 2020, representing some 190 million engagements.

Supporting physicians' mental health needs during the pandemic, the AMA launched a Behavioral Health Integration Collaborative in partnership with leading medical societies to provide practical steps to blend medical and behavioral health services with primary care.

The AMA rapidly **expanded its video programming across digital platforms**, including 200 episodes of the popular daily AMA COVID-19 Update, which resulted in a 900 percent increase in video minutes viewed in 2020.

Helping physicians and practices recover

We pushed the federal government to **accelerate production of life-saving PPE for physicians and frontline workers**, improve and expand testing capabilities, and revise guidelines for serological and antibody testing.

We developed a checklist that **provided physicians and administrators with strategies to sustain their practices**, and information about stimulus relief considerations and legal compliance during the pandemic.

The AMA's guide to "Creating a Resilient Organization" **offered 17 steps to caring for health care workers before, during and after COVID-19,** providing practical tips on coping during times of acute stress, and seeking to lower incidences of chronic stress illness and injury.

AMA Insurance's term-level life policies, customized for physicians, increased 22 percent amid the **uncertainty of 2020**.

The AMA Ed Hub™, our online education platform, expanded its offerings to **feature courses on COVID-19, infection prevention and control, health equity, and physician burnout and wellness**, contributing to a near 65 percent growth in views over 2019.

To serve the needs of the medical education community, the AMA developed the comprehensive AMA MedED COVID-19 resource guide as a platform to **inform and engage educators, residents and students in discussions about the pandemic**. AMA's Accelerating Change in Medical Education Consortium and "Reimagining Residency" initiative awarded three GME Innovation Grants at its inaugural (virtual) GME Innovation Summit.

Ankush Bansal, MD
Internal medicine

Sunny Jha, MD, MA
Anesthesiology

Reducing obstacles to patient care

At a pair of virtual special meetings, the AMA Board of Trustees and the AMA House of Delegates recognized racism and bias as an urgent threat to public health and **pledged to help dismantle racist and discriminatory policies** and practices across health care.

The AMA committed to a **$2 million, two-year investment in a Chicago-based collaborative** that focuses on addressing social determinants of health in the city's West Side neighborhood, advancing its work in health equity.

The AMA **developed training to better integrate health equity across the organization** and incorporated a diversity, equity and inclusion lens to help guide all convened groups to support our work.

The AMA partnered on national campaigns to **promote flu vaccinations** during the height of the pandemic and to encourage Americans to #MaskUp.

The AMA's Center for Health Equity helped lead a national conversation about the pandemic's disproportionate impact on communities of color, the importance of accurate, nationwide data collection, and **sought to advance policies that eliminated inequities**, supported equitable access to care and research, and improved culturally competent care.

The AMA worked in federal court to **protect international medical graduates**, and we joined 32 other leading health organizations in filing a successful *amicus* brief to ensure the U.S. Supreme Court upheld protections for physicians and medical students with Deferred Action for Childhood Arrivals status. AMA is a plaintiff in three federal cases, including one the U.S. Supreme Court agreed to review involving the Title X program before the Biden administration agreed to reverse the harmful gag rule. In addition, AMA has filed friend-of-the-court briefs in state and federal courts around the country on a wide range of critical issues, with more than 80 briefs filed in 2020 alone.

Tracey L. Henry, MD, MPH, MS
Internal medicine

Advocating for equitable, science-based care

The AMA successfully worked with the Centers for Medicare & Medicaid Services to **reduce physician documentation** relating to Evaluation and Management (E/M) reporting requirements, resulting in the first such overhaul of E/M codes in more than 25 years.

We continued to work at the state and national levels to **push for important prior authorization and step therapy reforms across** the U.S., keeping the focus on reducing the volume of prior authorization requirements and the impact on patient care. The AMA also provided state medical associations with support and resources to push policymakers to increase liability protections for physicians, pausing and then resuming nonurgent procedures, and needed flexibilities for treatment of opioid use disorders.

The AMA's STEPS Forward™ portfolio expanded with 12 new and 19 updated toolkits, educational modules, videos, podcasts and customizable resources to **help physicians and their teams streamline their workflows** for improved patient care.

We enlisted NORC at the University of Chicago to develop the first U.S. Blood Pressure Validated Device Listing™, and provided a health care organization with our first Blood Pressure Population Dashboard which, accompanied by our AMA MAP BP™ program, has **demonstrated increased blood pressure control**.

The AMA partnered with the American Heart Association, the National Medical Association and others on a national campaign to **promote better heart health in Black women**. The "Release the Pressure" campaign created culturally relevant resources to help Black women prioritize their blood pressure control and other aspect of self-care.

As we turn the corner in this pandemic and turn toward a new, more hopeful year, the AMA will continue to be by your side. We hope you'll continue to stand by ours, as we navigate this journey together.

2020

MANAGEMENT'S DISCUSSION AND ANALYSIS

Management's discussion and analysis

Columnar and chart amounts in millions

Introduction

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

Improving the health of the nation is at the core of the AMA's work. Our 2020 focus continues the strategic arcs of addressing chronic disease, professional development and removing obstacles in health care, through improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives act as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, talent and engagement.

2020 saw a focus on many important activities, including the successful first full year for AMA's Center for Health Equity, with a goal of embedding health equity in all the work of AMA; the creation of AMA's and the JAMA Network's COVID-19 resource centers evolving to trusted sources for clear, evidence-based COVID-19 guidance through research, publications, news and education; launch of the JAMA Health Forum, an online channel that addresses health policy and health strategy; leading the public sector response to the COVID-19 public health emergency which was the most pressing obstacle to physicians and patients in 2020; advocacy efforts and coding support for telemedicine; ongoing development of projects in the Integrated Health Model Initiative to enable interoperable technology solutions and care models; spinoffs of two new companies in AMA's business formation and commercialization enterprise in Silicon Valley, Health2047, Inc. (Health2047); and expansion of the AMA Ed Hub, providing trusted, high-quality education to physicians and other members of the health care team who seek to stay current and continuously improve the care they provide.

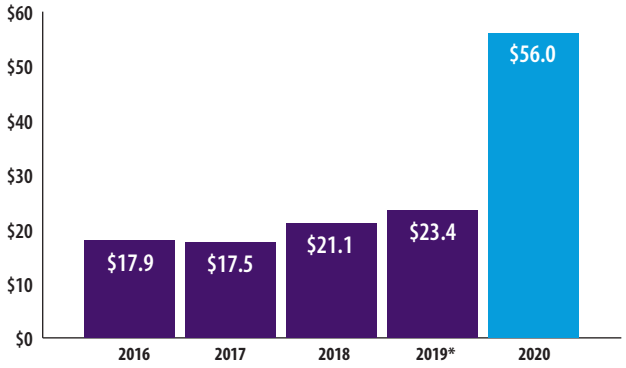
AMA recognized early in 2020 that the impact of COVID-19 was evolving rapidly and its future effects were uncertain. In addition to our responsibility to physicians and the public to be a credible source of information during this pandemic, there was substantial uncertainty about the effects and risks of COVID-19 on our funding, financial condition, and results of operations.

Although AMA expected that the impact on 2020 would be minimal, there was serious concern about AMA's ability to maintain programmatic activities and current employment levels during a sustained pandemic into 2021, knowing the potential for an adverse financial impact on the economy.

As a result, AMA put into place certain restrictions in 2020 in order to avoid increasing our financial obligations in 2021. These included a freeze on hiring, with only limited exceptions. AMA's 2020 overall revenues were not adversely impacted by the pandemic, as revenues increased over 10 percent, or $41.1 million. Despite the freeze on staff additions and absence of travel, expenses were up in 2020 by just over $8 million. However, due to the substantial revenue growth and the temporary absence of staffing and travel costs, AMA net operating income increased from $23.4 million in 2019 to $56 million in 2020. Based on these results and the development of vaccines, AMA maintains a positive outlook for its ability to sustain budgeted programmatic and mission-related activities in 2021.

Pro forma net operating results

(in millions)



**Excluding the $36.2 million non-cash pension termination charge*

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

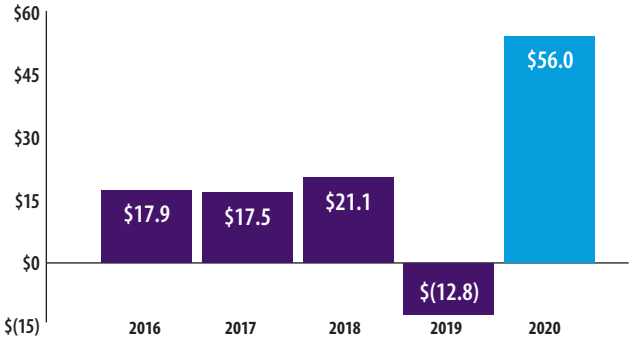
The following pages discuss the 2020 consolidated results from operations, financial position and cash flows, as compared to 2019. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the freeze on hiring and travel put in place during 2020 to protect AMA against the economic impact of a sustained pandemic into 2021 restrained spending substantially in 2020, while at the same time, revenue rose by over 10 percent, driving AMA's net operating income to $56 million. AMA does not expect to continue the limitations on spending throughout 2021 and future results are expected to be more modest.

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

Excluding the $36.2 million noncash pension termination expense (net of the $2 million tax credit), AMA would have reported $23.4 million in net operating income for 2019.

Results discussed below reflect AMA's actual results from operations, including the one-time noncash pension termination expense in 2019. Any discussion of results excluding the one-time pension termination expense will be described as pro forma results for 2019.

Revenues

In 2020, total revenues improved by $41.1 million over the prior year, due to continued growth in AMA's royalties, as well as journal advertising, site licensing and open access fees. Coding book sales declined during 2020, reflecting the ongoing transition from print to digital.

Consolidated investment income, which is dividend and interest income, net of management fees, decreased $3.9 million in 2020, reflecting a decline in interest rates since 2019, as well as the impact of reallocating investments to a growth manager, which reduced dividend income. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying memberships increased in 2020 by almost 7 percent, achieving 10 years of consecutive growth in membership, despite AMA's decision to cease solicitations in the early months of the pandemic and to reallocate funds toward providing COVID-19 resources for physicians. Over that ten-year period, AMA membership increased by over 68,000 members.

Similar to results in previous years, increases occurred in lower dues paying categories such as group memberships and sponsored memberships, which resulted in a small dues revenue decline of just under 2 percent.

Cost of products sold and selling expenses

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

In 2020, cost of products sold and selling expenses increased $1.5 million from the prior year, mainly due to $1.6 million in production costs on a $2.6 million revenue contract in Health2047 for custom applications.

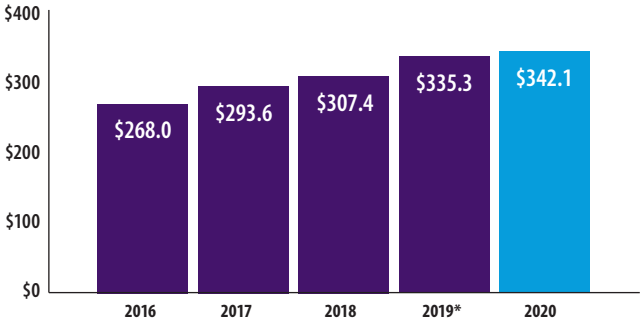
Contribution to general and administrative expenses

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

The contribution to general and administrative expenses increased $39.6 million to $404.1 million in 2020, with revenue improvements from royalties and journal publishing, offset by the declining book sales discussed above, accounting for most of the change.

Pro forma general and administrative expenses

(in millions)



**Excluding the $36.2 million non-cash pension termination charge*

General and administrative expenses rose only $6.8 million in 2020, or 2 percent, when compared to the pro forma expenses in 2019 that excluded the pension termination expense. This was substantially less than the budgeted increase for 2020 of 13 percent primarily due to the freeze on hiring and lack of travel during the pandemic.

Compensation and benefits increased $12.9 million, or approximately 6 percent. Compensation, including temporary help, was $13.7 million higher in 2020, a 9.9 percent increase. Staff additions hired in late 2019 or early 2020, as well as salary increases, accounted for $11.1 million of the change. Costs for an additional one-time vacation carryover from 2020 totaled $2.5 million. Fringe benefit costs declined $3.5 million in total, mainly due to the absence of pension costs coupled with lower medical costs. Higher incentive compensation accounted for $3.5 million of the increase in compensation and benefits as the salary base increased and key performance indicators were achieved in 2020. Recruiting costs also declined in 2020 due to the freeze on hiring during the pandemic.

Occupancy costs decreased $0.7 million in 2020, largely due to reduced operating costs resulting from closing the office buildings in Chicago and Washington, D.C. during the pandemic.

Travel and meeting costs dropped by $13.9 million in 2020, due to the pandemic.

Technology costs were down slightly in 2020, mainly due to the adoption of a new accounting standard that requires deferring development costs for hosted solutions and expensing the cost over the life of the hosting contract. In 2019, prior to adoption of the new standard, all development costs for hosted solutions were expensed upon payment.

Marketing and promotion costs rose $1.3 million in 2020, due to a variety of media campaigns including the Health Insurer Practice Campaign, a social media and online campaign generating awareness around negative health insurance practices; AMA's COVID-19 response; the No One Has Time for Flu campaign on vaccine awareness; and the Essence Release the Pressure campaign for blood pressure control.

Outside professional services increased $5.9 million in 2020, mainly for chronic health care projects, the Joy in Medicine Recognition Program, development of physician practice resources, strategy development for the Center for Health Equity and implementation of a new AMA Insurance Agency policy administration system.

Other operating expenses rose $1.8 million, driven by increased grants for the Reimagining Residency and the Joy in Medicine Recognition programs and a lease tax assessed by the City of Chicago on hosted solutions used by AMA, offset by the absence of a reserve for bad debts that had been recorded in 2019.

Operating results before income taxes

The AMA reported $62 million in pre-tax operating income in 2020. That compares to $29.2 million in 2019, which excludes the $38.2 million noncash pension termination expense. A $41.1 million increase in revenue was only partially reduced by the general and administrative expense increases described above.

Income taxes

Taxes increased slightly in 2020 when compared to 2019, excluding the $2 million noncash tax benefit related to the pension plan termination in 2019.

Net operating results

Net operating income was $56 million in 2020 compared to $23.4 million in 2019, excluding the pension termination expense in 2019, driven mainly by improved revenues and small expense increases.

Non-operating items

The AMA reported a $58.4 million gain in the fair value of its portfolio during 2020 after a $75 million gain in 2019.

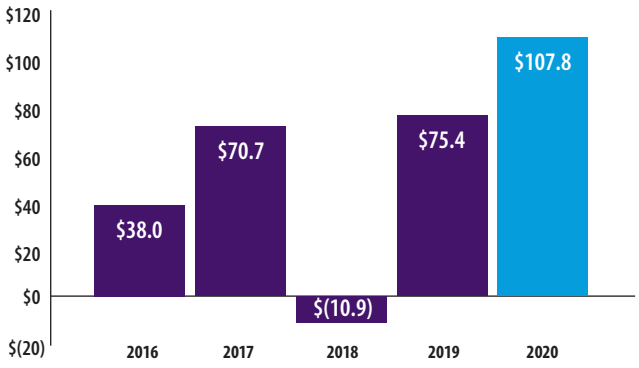
As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include $2.5 million and $3.9 million in postretirement plan interest expense and recognized actuarial losses for 2020 and 2019, respectively.

Revenue in excess of (less than) expenses

Revenues exceeded expenses by $112.1 million in 2020, a combination of $56 million in operating income, a $58.4 million gain in fair value in the portfolio and $2.3 million in other non-operating expenses. Revenues exceeded expenses by $58.5 million in 2019, a combination of the $12.8 million operating loss, the $75 million gain in fair value in the portfolio and $3.7 million in other non-operating expenses.

Change in total association equity

(in millions)



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

In 2020, AMA recorded a $2.8 million charge to equity reflecting an increase in actuarial losses for the postretirement healthcare plan and a reclassification of prior service credits for the plan to operating expense.

In 2019, the net credit to equity related to defined benefit postretirement plans totaled $17 million. This included a noncash credit of $36.2 million due to reclassifying prior actuarial losses and prior service cost for the pension plan to operating expense, upon finalizing the pension plan termination. Excluding the $36.2 million credit from reclassifying the pension plan expense to operating expense, the AMA reported a $19.2 million charge to equity for the postretirement health care plan. Actuarial losses due to year-end lower interest rates that increased the present value of plan liabilities accounted for $18.2 million of the charge.

The AMA reported a $107.8 million increase in association equity in 2020. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a $1.5 million decrease in donor-restricted equity due to release of previously restricted funds.

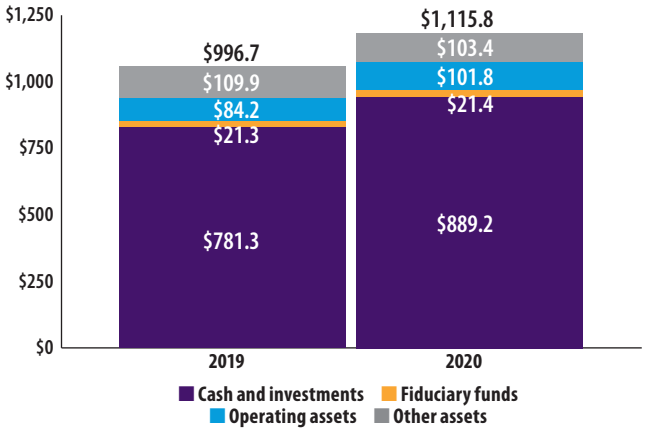
The AMA reported a $75.4 million increase in association equity in 2019, which included the amount by which revenues exceeded expenses, plus the credits to equity for changes in defined benefit postretirement plans discussed above and less a small decrease in donor-restricted equity.

Financial position and cash flows

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

Assets

(in millions)



The AMA's total assets increased $119.1 million in 2020. This includes a $107.9 million increase in cash and investments resulting from $51 million in free cash flow, a $58.4 million gain in the fair value of investment securities, minus $1.5 million for investments in affiliates.

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

Operating assets increased $17.6 million in 2020, primarily due to a $15.1 million increase in accounts receivable from higher fourth quarter royalty revenue. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets includes operating lease right-of-use assets, property and equipment and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets decreased due to amortization of the asset that represents the present value of lease payments. Property and equipment net book value decreased $1.2 million, as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

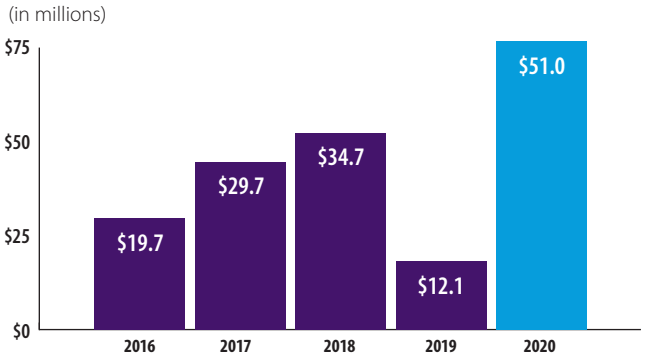
Operating liabilities increased $7.2 million in 2020, largely due to an increase in postretirement health care plan liabilities and other accrued payroll costs included in accrued payroll and employee benefits.

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

Cash flows

Cash, cash equivalents and donor-restricted cash increased $4.1 million in 2020 and declined $10.4 million in 2019. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash

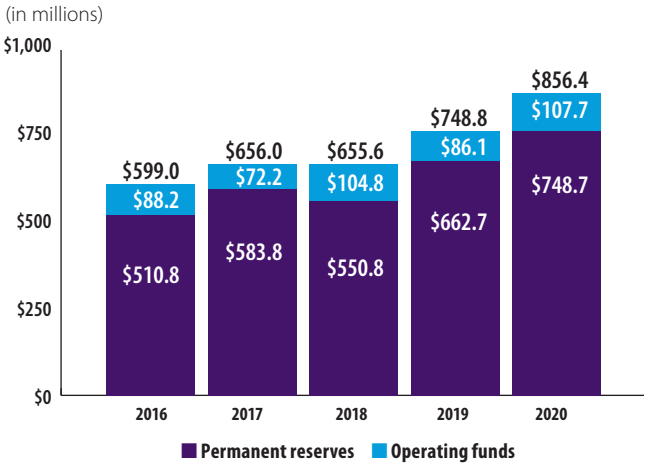


Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash in 2020 totaled $51 million, substantially higher than the 2019 results, driven by a $39.3 million increase in cash from operations reduced by slightly higher capital spending. The increase in cash from operations was mainly due to improved operating results and the absence of the final $7 million pension contribution made in 2019.

Reserve portfolios

Reserves



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

As of year-end 2020, the reserve portfolio's value was $748.7 million compared to $662.7 million in 2019, an $86 million increase. That increase was the result of a $57.7 million gain in the fair value of the reserve portfolios plus a $28.9 million transfer of 2019 excess operating funds to reserves. Operating funds totaled $107.7 million in 2020, up $21.6 million from 2019.

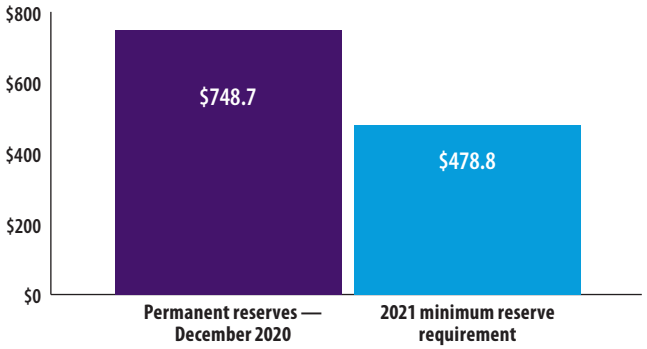
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value).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

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

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

Permanent reserves and minimum reserve requirement

(in millions)



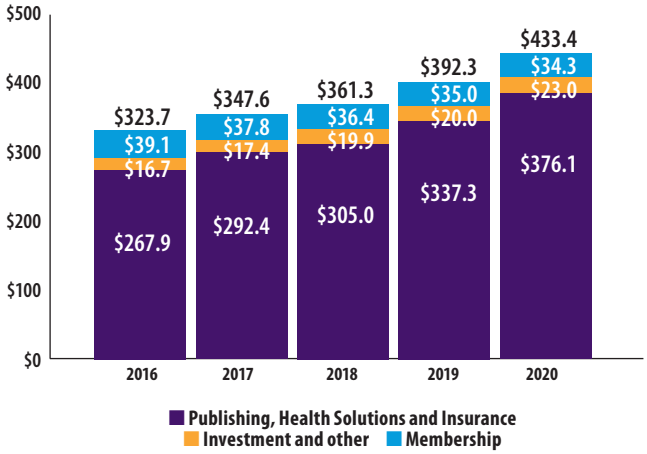
Group operating results

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

Revenues

Total revenue

(in millions)



Membership

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

The AMA achieved its tenth consecutive year of increases in the number of dues-paying members, although total dues revenue declined in 2020. The number of dues paying members increased 6.7 percent and total membership increased 6 percent in 2020. Membership growth in 2020 was favorably impacted by employing digital tools to more effectively engage physicians and retain them as lifelong members; group membership marketing; and expanding AMA's reach to physicians through programmatic activities.

Dues revenue was $34.4 million, a $0.7 million decrease from 2019, as membership increased in categories with lower average dues rates, such as group practices, retirees, residents and sponsored memberships. Interest expense on lifetime memberships was $0.1 million in both 2020 and 2019.

Investments (AMA-only)

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

Investments' income was $11.4 million in 2020, a $3.1 million decrease over the prior year, due to two factors. Interest rates had improved in early 2019 but then dropped back to historic low levels at the end of 2019 through 2020. In addition, certain portfolio assets were reallocated from a value manager to a growth manager resulting in reduced dividend income.

The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above. In 2020, AMA reported a gain of $58.4 million, compared to a $75 million gain in 2019. The total investment return, including investment income, on the reserve portfolios was 10.4 percent. That compares to a composite benchmark index of 10.5 percent.

Publishing, Health Solutions and Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In 2020, the JAMA Network launched JAMA Health Forum, an online channel that addresses health policy and health strategy issues affecting medicine and health care, combining curated content from across the JAMA Network with weekly blog posts by leaders in health policy. This follows the successful launches of *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles, and *JAMA Network Open* in 2018, a fully open access journal.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues increased $4.7 million in 2020, with a rebound in print advertising coupled with growth in journal site licensing and open access fees.

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

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues were largely unchanged in 2020, up $0.3 million when compared to 2019.

AMA-published books and coding products, such as CPT books, workshops and licensed data files, make up the Books and Digital Content unit. Revenues in this unit increased by $34.9 million. Royalties and digital content sales drove this increase, as the market for electronic use of digital coding products continues to expand. A change in the pricing models for 2020 was also a key factor. Coding book sales declined again in 2020 as the move from print products to digital continues to adversely impact print product sales.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Insurance Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis. The Insurance Agency revenues dropped by $1.1 million in 2020, mainly due to a decrease in commission rates and the impact of lower interest rates on interest income. The Insurance Agency, as broker, receives a commission on insurance policies sold.

Other revenues

Other revenues are derived from grants, fee and miscellaneous income. These increased $1.9 million in 2020, due to a combination of releasing donor restricted funds and a premium refund related to the purchase of the pension group annuity contract in 2019. Health2047 revenues are discussed separately at the end of this discussion and analysis.

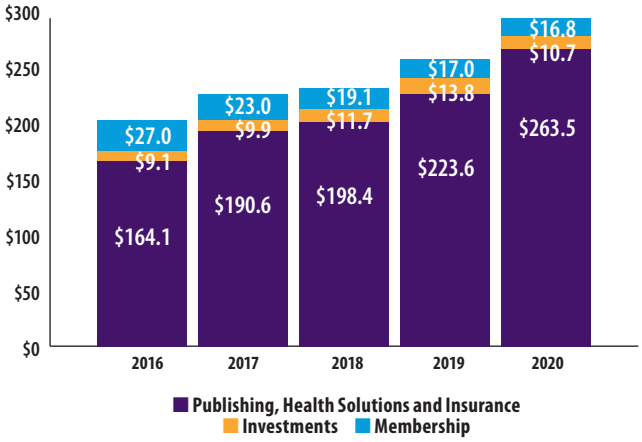
Contribution margin (net expenses)

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

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

Contribution margin

(in millions)



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

Membership

Membership's contribution margin decreased $0.2 million in 2020 with a small dues revenue decline, offset by savings on marketing efforts during the pandemic.

Investments (AMA-only)

The $3.1 million decline in contribution margin was attributable to lower investment revenue.

Publishing, Health Solutions and Insurance

Publishing, Health Solutions & Insurance results were up $39.9 million in 2020. Increased royalty and digital products revenue, site licensing, journal print advertising and open access fees were the major drivers.

Contribution margin improved $5.1 million in Publishing, a combination of the $4.7 million revenue increase and cost savings, mainly from reduced travel.

Database Products reported a $1.7 million margin improvement as the improved royalty revenue was coupled with lower expenses, largely due to the absence of costs incurred in 2019 for a new technology platform.

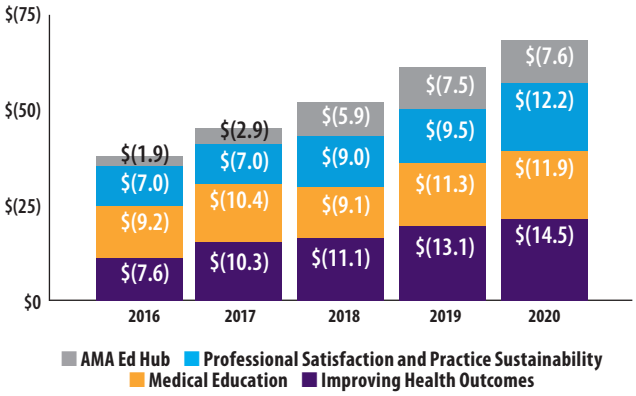
Books and Digital Content contribution margin rose $34.5 million, largely on the strength of continued growth in royalties and digital product revenues, offset slightly by costs to improve operational and international distribution capability.

The Insurance Agency/Affinity Products margin decreased $1.6 million in 2020, due to the revenue decline discussed earlier as well as costs for the new technology platform.

Other business operations net expenses were down slightly in 2020.

Net expenses - Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the units for Improving Health Outcomes (IHO), Medical Education including Accelerating Change in Medical Education (ACE), the AMA Ed Hub and Professional Satisfaction and Practice Sustainability (PS2).

IHO involves AMA focusing on two of the nation's most prevalent issues: Cardiovascular disease and type-2 diabetes, setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions.

To help prevent type-2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at risk patients to in-person or online diabetes prevention programs (DPPs).

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help manage their patients' high blood pressure (BP). These resources are available to all physicians and health systems as part of Target: BP™, a national initiative co-led by the AMA and the American Heart Association.

In 2020, the focus remained on hypertension and prediabetes outcome goals with groundwork for moving toward cardiovascular disease risk reduction pilots of cloud-based, M.A.P. BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards for health care organizations, providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender.

2020 also saw an emphasis on self-measured blood pressure (SMBP) in light of COVID-19, with new physician tools for effective SMBP, a validated device listing (VDL) and wrap around SMBP support to Chicago west side clinics. Net expenses continued to increase in 2020, reflecting designed expansion for these initiatives.

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

One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. The AMA has created the Health Systems Science Scholars program to cultivate a national community of medical educators and health care leaders who will drive the necessary transformation to achieve improved patient experience, improved health populations and reduced cost of care. Medical Education is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. There was only a small increase in net expenses during 2020, as $1.8 million in additional ACE grants were partially offset by a substantial decrease in travel and meeting costs.

The AMA Ed Hub, formally launched in 2018, is a platform providing physicians and other health care providers content and services that support lifelong professional development. The AMA Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets and established internal development plans enterprise wide. The Ed Hub also gives physicians and other health professionals a streamlined

way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. Net expenses were largely unchanged in 2020 from 2019.

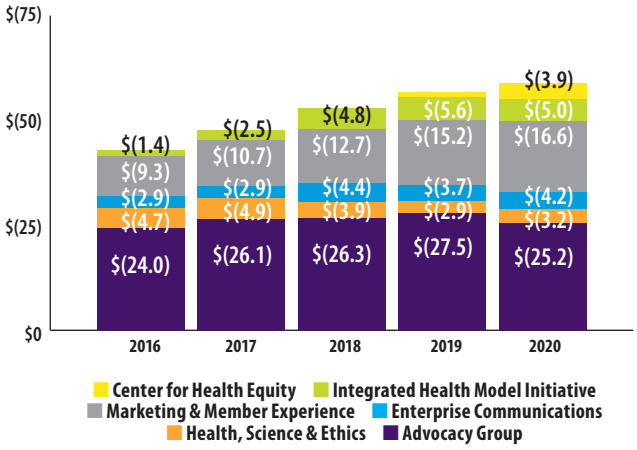
PS2 includes three major streams of work: practice transformation, digital health, and payment and quality, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care.

The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2020, efforts shifted toward providing COVID-19 resources as well as practice management, with well over 100,000 physicians and residents impacted by PS2's efforts. In 2020, net expenses increased by $2.7 million including a $1.2 million increase in practice transformation grants and a $1.2 million increase in outside professional services related to major projects on physician practice resources and digital health.

Core activities

(in millions)



Core Activities includes six groups: Advocacy; Health, Science & Ethics, Center for Health Equity, Integrated Health Model Initiative (IHMI), Enterprise Communications and Marketing & Member Experience (MMX).

The Advocacy Group includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. The Advocacy Group led the AMA's public sector response to the COVID-19 public health emergency which was the most pressing obstacle to physicians and patients in 2020. COVID-19 led to dual crises – public health and economic. AMA worked with the Administration, Congress, federal and state agencies, and state legislatures to address both. AMA secured emergency funding for physician practices; pressed FDA to approve increased/more accurate testing; obtained a broad telehealth expansion; achieved payment for both audio-visual and audio-only telemedicine; sought demographic data on infections/deaths to highlight inequities; urged federal/state leaders to follow public health guidelines; and highlighted PPE shortages among other activities. In 2020, Advocacy net spending totaled $25.2 million, down $2.3 million from the prior year. Declines in travel and meetings, occupancy costs in the DC offices and grant expenses all contributed to the reduction in net expenses.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates (HOD) providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the *AMA Journal of Ethics*, AMA's online ethics journal; and selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships through the United States Adopted Names (USAN) program. In 2020, this group led the AMA's COVID-19 efforts by providing subject matter expertise and content, increased grant funding for public health-related work through a multi-million-dollar CDC grant, and developed and launched a strategic plan for precision medicine. Net expenses increased $0.3 million, mainly due to expenses for participating in a national campaign to provide science-based information on the flu vaccine.

AMA recognized that a key to long-term success in our strategic arcs is increasing our efforts to reduce health and health care disparities. As a result of a 2018 task force report, the AMA sought leadership to embed health equity initiatives as relevant into all strategic priorities and areas of the organization, creating a new group, the Center for Health

Equity (CHE). The focus of this newly created group is to meaningfully and significantly operationalize health equity in AMA strategic, business, membership and collaborative efforts. During its first full year of operations, efforts focused on establishing an AMA presence in the health equity research literature that reflects our alliances with other organizations and external thought leaders; strengthening AMA assets into place-based community-driven efforts such as the collaborative on Chicago's west side called West Side United; building staff capacity to understand concepts surrounding health equity and to operationalize equity in goal and metric setting, aligning with Advocacy to engage with health equity leaders and elected officials and developing structural competency learning tools. Since CHE was in the first full year of operations, it was exempted from the freeze on new employees. As a result, CHE net spending rose in 2020 to $3.9 million from $0.8 million in its first partial year of operations in 2019.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) FHIR (Fast Healthcare Interoperability Resources), the Gravity Project and others. In 2020, IHMI received recognition within the digital health community for work in developing Social Determinants of Health (SDoH) and data standards and promoting interoperability. IHMI also collaborates on projects with other organizations across the health care industry to make health data more useful and actionable and supports areas across AMA around innovation and technology solutions. IHMI net expenses declined $0.6 million in 2020, due to a decrease in compensation and travel.

MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. In 2020, over 20 million unique individuals accessed AMA's website, a 66 percent increase over the prior year, driven by AMA's COVID-19 Resource Center and other compelling editorial, video, and social content developed during 2020, which accounted for most of the $1.4 million increase in net expenses in 2020.

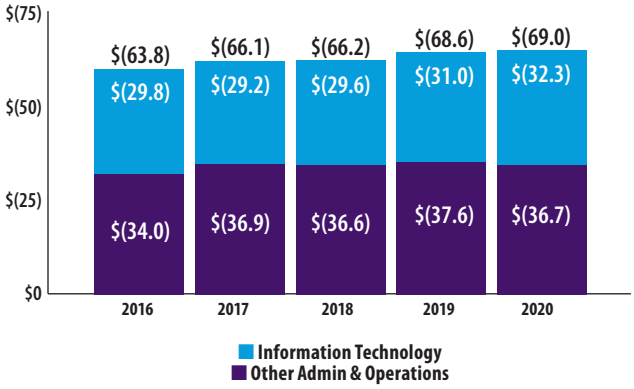
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care. Net expenses increased by $0.5 million in 2020, largely due to use of outside professional services on a major communications project.

Governance

Governance includes the Board of Trustees and Officer Services, the HOD, Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs and Core Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2020, Governance net spending was down $5.1 million, almost entirely due to the absence of travel and in-person meetings due to the pandemic.

Administration and operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs and Core Activities, as well as other operating groups. Net expenses were up slightly in 2020, an increase of $0.4 million. Staff expansion and increased use of consultants in Information Technology accounted for most of the increase. Senior Executive Management costs declined and the remaining units reported little or no change in costs.

Affiliated organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. Net expenses decreased $0.9 million in 2020 as 2019 results included a $0.8 million one-time grant to an affiliated entity.

Unallocated overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2020, these expenses totaled $32.7 million, up from $24.7 million in 2019. Due to the pandemic, AMA changed its vacation policy to permit a one-time carryover of five additional days per employee which was expensed as required under accounting standards. Higher incentive compensation and a reserve for the Chicago lease tax on hosted solutions used by AMA were also factors in the increase.

Health2047 and subsidiaries

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

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

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

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

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

Health2047 revenue in 2020 was $2.3 million, compared to a $1.9 million loss in 2019. In 2020, Health2047 recognized revenue and associated costs for creating custom applications for a customer, with revenue of $2.6 million. Health2047 reflects its proportionate loss in earnings of affiliates as a contra revenue, totaling $0.6 million and $2.2 million in 2020 and 2019, respectively. Health2047 also has $0.3 million in investment income and other income in both years.

Expenses declined in 2020 by $1.6 million, as costs for the custom apps were more than offset by the absence of a large reserve for bad debts in 2019 and reduced operating costs in Akiri. The combination of increased revenue, reduced losses from affiliates and lower expenses resulted in a $5.8 million decrease in net expenses in 2020. This reflects the proportionate share of results for all Health2047 companies.

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

American Medical Association group operating results

	Revenues		Margin (expenses)	
(in millions)	**2020**	**2019**	**2020**	**2019**
Membership	**$ 34.3**	$ 35.0	**$ 16.8**	$ 17.0
Publishing, Health Solutions & Insurance				
Publishing	**64.9**	60.2	**9.9**	4.8
Database Products	**59.7**	59.4	**47.6**	45.9
Books and Digital Content	**211.7**	176.8	**186.7**	152.2
Insurance Agency/Affinity Products	**39.8**	40.9	**21.9**	23.5
Other business operations	**-**	-	**(2.6)**	(2.8)
	376.1	337.3	**263.5**	223.6
Investments (AMA-only)	**11.4**	14.5	**10.7**	13.8
Strategic Focus Areas & Core Operations				
Improving Health Outcomes	**0.1**	0.1	**(14.5)**	(13.1)
Medical Education/Accelerating Change in Medical Education	**0.2**	0.5	**(11.9)**	(11.3)
Professional Satisfaction and Practice Sustainability	**-**	0.5	**(12.2)**	(9.5)
Integrated Health Model Initiative	**-**	-	**(5.0)**	(5.6)
Advocacy	**2.1**	0.7	**(25.2)**	(27.5)
Health, Science, & Ethics	**4.1**	4.2	**(3.2)**	(2.9)
Center for Health Equity	**0.2**	-	**(3.9)**	(0.8)
AMA Ed Hub	**0.2**	0.3	**(7.6)**	(7.5)
Enterprise Communications	**-**	-	**(4.2)**	(3.7)
Marketing and Member Experience	**-**	-	**(16.6)**	(15.2)
	6.9	6.3	**(104.3)**	(97.1)
Governance				
Board of Trustees and Officer Services	**-**	-	**(4.9)**	(6.3)
House of Delegates, Sections, Special Constituencies & International	**-**	0.1	**(5.4)**	(9.1)
	-	0.1	**(10.3)**	(15.4)
Administration and operations				
Information Technology	**-**	-	**(32.3)**	(31.0)
Senior Executive Management	**-**	-	**(4.5)**	(5.2)
General Counsel	**-**	-	**(6.5)**	(6.4)
Finance & Risk Management	**-**	-	**(7.0)**	(7.0)
Human Resources	**-**	-	**(6.3)**	(6.3)
Corporate Services	**-**	-	**(5.5)**	(5.5)
Customer Service	**-**	-	**(3.2)**	(3.3)
Strategic Planning and Health Analytics	**-**	-	**(3.7)**	(3.9)
	-	-	**(69.0)**	(68.6)
Affiliated Organizations	**0.1**	0.1	**-**	(0.9)
Unallocated Overhead	**2.3**	0.9	**(32.7)**	(24.7)
Health2047 & Subsidiaries	**2.3**	(1.9)	**(12.7)**	(18.5)
Consolidated revenue and income before tax and noncash pension termination expense	**$ 433.4**	$ 392.3	**62.0**	29.2
Income tax expense (excluding pension termination benefit)			**(6.0)**	(5.8)
Consolidated net operating income – pro forma			**56.0**	23.4
Noncash pension termination expense, net of tax			**-**	(36.2)
Consolidated net operating income (loss)			**$ 56.0**	$ (12.8)

2020

CONSOLIDATED FINANCIAL STATEMENTS

American Medical Association and subsidiaries

Consolidated statements of activities

Years ended December 31

(in millions)	2020	2019
Revenues		
Membership dues	$ 34.4	$ 35.1
Advertising	13.6	11.9
Journal print subscription revenues	3.7	4.2
Journal online revenues	29.8	28.7
Other publishing revenue	16.9	14.8
Books, newsletters and online product sales	25.7	27.4
Royalties and credentialing products	245.1	208.4
Insurance commissions	36.7	37.0
Investment income (Note 4)	11.6	15.5
Equity in losses of affiliates (Note 2)	(0.6)	(2.2)
Grants and other income	16.5	11.5
Total revenues	**433.4**	**392.3**
Expenses		
Cost of products sold and selling expenses	29.3	27.8
Contribution to general and administrative expenses	**404.1**	**364.5**
General and administrative expenses		
Compensation and benefits	217.4	204.5
Occupancy	21.1	21.8
Travel and meetings	4.1	18.0
Technology costs	26.0	26.7
Marketing and promotion	17.5	16.2
Professional services and consulting	30.1	24.0
Other operating expenses	25.9	24.1
Pension termination expense (Note 7)	-	38.2
Total general and administrative expenses	**342.1**	**373.5**
Operating results before income taxes	62.0	(9.0)
Income taxes (Note 9)	6.0	3.8
Net operating results	**56.0**	**(12.8)**
Non-operating items		
Net gain on investments (Note 4)	58.4	75.0
Defined benefit postretirement plan non-service periodic expense (Note 8)	(2.5)	(3.9)
Other	0.2	0.2
Total non-operating items	**56.1**	**71.3**
Revenues in excess of expenses	**112.1**	**58.5**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 7, 8 and 9)	(2.8)	17.0
Change in association equity	**109.3**	**75.5**
Change in donor restricted association equity		
Restricted contributions	0.3	0.3
Net assets released from restriction	(1.8)	(0.4)
Change in association equity – donor restricted	**(1.5)**	**(0.1)**
Change in total association equity	**107.8**	**75.4**
Total association equity at beginning of year	624.2	548.8
Total association equity at end of year	**$ 732.0**	**$ 624.2**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2020	2019
Assets		
Cash, cash equivalents and donor-restricted cash	$ 35.0	$ 30.9
Fiduciary funds (Note 2)	21.4	21.3
Investments in affiliates (Note 2)	1.0	-
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.4 in 2020 and $0.3 in 2019	82.8	67.7
Inventories	2.3	2.7
Prepaid expenses and deposits	10.8	8.9
Deferred income taxes (Note 9)	4.9	4.9
Investments (Note 4)	854.2	750.4
Property and equipment, net (Note 6)	43.3	44.5
Operating lease right-of-use assets (Note 10)	52.0	56.6
Other assets (Note 5)	8.1	8.8
	$1,115.8	**$ 996.7**
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 17.4	$ 16.6
Accrued payroll and employee benefits (Notes 7 and 8)	169.3	157.1
Insurance premiums and other fiduciary funds payable	21.5	21.2
Income taxes payable (Note 9)	2.1	0.8
Operating lease liability (Note 10)	85.7	93.1
	296.0	288.8
Deferred revenue		
Membership dues	16.4	15.9
Subscriptions, licensing, insurance commissions and royalties	68.4	65.4
Grants and other	3.0	2.4
	87.8	83.7
Association equity	731.9	622.6
Donor-restricted association equity	0.1	1.6
Total association equity	732.0	624.2
	$1,115.8	**$ 996.7**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of cash flows

Years ended December 31

(in millions)	2020	2019
Cash flows from operating activities		
Change in total association equity	$ 107.8	$ 75.4
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	12.6	12.3
Pension and postretirement health care expense	4.0	8.7
Noncash operating lease expense	10.0	10.1
Net gain on investments	(58.4)	(75.0)
Equity in losses of affiliates	0.6	2.2
Contribution to pension plan	-	(7.0)
Noncash charge for changes in defined benefit plans other than periodic expense (including pension termination expense in 2019) net of tax	2.8	19.2
Bad debt expense	0.1	2.3
Other	(0.1)	(0.2)
Changes in assets and liabilities		
Accounts receivable and other receivables	(15.2)	(13.3)
Inventories	0.4	(0.5)
Prepaid expenses and deposits	(1.9)	(2.7)
Other assets	1.6	-
Accounts payable, accrued liabilities and income taxes payable	(6.4)	(12.1)
Deferred revenue	4.1	3.3
Net cash provided by operating activities	62.0	22.7
Cash flows from investing activities		
Purchase of property and equipment	(11.0)	(10.6)
Investment in affiliates	(1.5)	(2.2)
Purchase of investments	(636.9)	(486.9)
Proceeds from sale of investments	591.5	466.6
Net cash used in investing activities	(57.9)	(33.1)
Net change in cash, cash equivalents and donor restricted cash	4.1	(10.4)
Cash, cash equivalents and donor restricted cash at beginning of year	30.9	41.3
Cash, cash equivalents and donor restricted cash at end of year	**$ 35.0**	**$ 30.9**
Noncash investing activities		
Noncash exchange of convertible debt for investment in affiliate (Note 2)	$ 1.7	$ -
Accounts payable for property and equipment additions	$ 0.9	$ 0.5

See accompanying notes to the consolidated financial statements.

Notes to financial statements

For the Years Ended December 31, 2020 and 2019
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 272 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

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

Donor-restricted association equity includes contributions for scope of practice, restricted for use to areas involved in scope issues and are not available for general use by AMA. Funds previously restricted for use in a national tort reform campaign were released in 2020.

2. Significant accounting policies

Consolidation policy

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

AMA, through its wholly owned subsidiary, Health2047 has investments in four affiliates: HXSquare, Inc., formed in January 2019, Zing Health Enterprises LP (previously named Zing Health Holdings Inc.), formed in March 2019, Medcurio, Inc., formed in February 2020, and Health2047 Spinout Corporation, formed August 2020. The equity method of accounting is used to account for investments in affiliates in which the AMA has significant influence but not overall control. The investments were initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. The investment will be increased or reduced by any future additional contributions and distributions received, respectively.

At December 31, 2020, AMA ownership interest is 35.1% in HXSquare, Inc., 14.1% in Zing Health Enterprises, LP (Zing), 11.8% in Medcurio, Inc. (Medcurio), and 28.9% in Health2047 Spinout Corporation. During 2020, the AMA ceased application of the equity method to account for investments in Zing Health Enterprises, LP and Medcurio, Inc., as additional third-party investment in these entities resulted in AMA no longer exercising significant influence over these entities. In addition, in 2020 Zing Health Enterprises, LP was formed and holdings in convertible debt of Zing Health Holdings, Inc. was converted to Class B shares in Zing Health Enterprises, LP. The investment in Zing and Medcurio will be accounted for using the cost method. At the end of 2020, the book value of the equity method investment in HXSquare, Inc., net of convertible debt, and Health2047 Spinout Corporation was approximately zero.

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

Use of estimates

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

Cash equivalents

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

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc. (Agency), in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.7 million held at December 31, 2020 and 2019.

Inventories

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

Property and equipment

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

Revenue recognition

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

Nature of products and services

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

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

Contract balances

Timing of revenue recognition may differ from the timing of invoicing to customers. AMA records a receivable when revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or made available. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $77.7 million and $66 million as of December 31, 2020 and 2019, respectively.

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

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

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

Income taxes

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

Reclassifications

Certain reclassifications have been made in the notes to the consolidated financial statements to conform the 2019 amounts to the 2020 presentation.

3. New accounting standards update

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

The AMA adopted this guidance effective January 1, 2019, and classified the components of net periodic postretirement benefit cost other than service costs from compensation and benefits expense to non-operating expense within the consolidated statements of activities for all periods presented.

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

In October 2018, the FASB issued ASU No. 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*. This aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The AMA adopted this guidance on a prospective basis effective January 1, 2020. The adoption of this standard did not have a material impact on the AMA's consolidated financial statements.

4. Investments

Investments include marketable securities and venture capital private equity investments that are carried at fair value.

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

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

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

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

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

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

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

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

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

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

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

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

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

Investments also include investments in a diversified closed end private equity fund with a focus on buyout opportunities in the United States and the European Union, as well as investments in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2020 totaled $48 million.

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

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

	2020	2019
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 415.2	$ 341.2
Fixed-income mutual funds	19.5	15.4
	434.7	356.6
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	105.7	94.9
U.S. government and federal agency	247.5	247.4
Foreign government	26.3	25.9
U.S. state government	0.2	0.2
	379.7	368.4
Level 3 – Significant Unobservable inputs	-	-
Other investments measured at NAV – Private equity and venture capital funds	39.8	25.4
Investments	$ 854.2	$ 750.4

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

Investment income consists of:

	2020	2019
Investment dividend and interest income	$ 14.3	$ 18.1
Management fees	(2.7)	(2.6)
	$ 11.6	$ 15.5

Non-operating items include:

	2020	2019
Realized (losses) gains on investments, net	$ (1.9)	$ 14.9
Unrealized gains on investments, net	60.3	60.1
	$ 58.4	$ 75.0

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $8.1 million and $7.2 million at 2020 and 2019, respectively.

Expenses related to the development of custom applications pursuant to a customer contract had been deferred until completion of development and recognition of the revenue under the contract. Deferred costs of $1.6 million as of December 31, 2019 were recognized during 2020.

6. Property and equipment

Property and equipment at December 31 consists of:

	2020	2019
Leasehold improvements	$ 38.7	$ 38.4
Furniture and office equipment	19.5	19.1
Information technology		
Hardware	12.6	12.1
Software	96.4	87.2
	167.2	156.8
Accumulated depreciation and amortization	(123.9)	(112.3)
	$ 43.3	$ 44.5

7. Retirement pension and savings plans

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

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

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

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

	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ -	$ 117.5
Interest cost	-	4.2
Benefits paid	-	(6.0)
Termination benefit payments	-	(117.7)
Actuarial loss	-	2.0
Benefit obligation at end of year	$ -	$ -
Change in plan assets		
Fair value of plan assets at beginning of year	$ -	$ 113.5
Return on plan assets	-	2.4
Employer contributions	-	7.0
Benefits paid	-	(6.0)
Termination benefit payments	-	(117.7)
Plan combination	-	0.8
Fair value of plan assets at end of year	$ -	$ -

There were no pension plan accumulated losses and prior service costs not yet recognized as a component of periodic pension expense but included in accumulated other comprehensive loss at December 31, 2020 or 2019.

As discussed in Note 3, AMA did not adopt the new accounting standard for costs related to the pension plan due to the plan termination in 2019.

The AMA recognized pension expense in its consolidated statements of activities. The provisions of ASC Topic 958-715 required the AMA to recognize settlement charges based on the lump-sum benefit payments in 2019. The components of pension expense were:

	2020	2019
Interest cost	$ -	$ 4.2
Expected return on plan assets	-	(4.9)
Lump-sum settlement charges	-	1.2
Recognition of prior service cost	-	0.2
Recognition of actuarial losses	-	2.4
Pension expense	$ -	$ 3.1

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

	2020	2019
Actuarial losses	$ -	$ 37.6
Prior service cost	-	1.4
Plan combination	-	(0.8)
	$ -	$ 38.2

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

	2020	2019
Actuarial losses arising during period	$ -	$ (4.5)
Reclassification adjustment for losses reflected in periodic pension expense	-	3.8
Actuarial losses reclassified to expense related to plan termination	-	37.6
Prior service cost reclassified to expense related to plan termination	-	1.4
Change in unrestricted equity	$ -	$ 38.3

Actuarial assumptions used in determining pension expense were:

	2020	2019
Discount rate	NA	4.1%
Expected long-term return on plan assets	NA	4.8%

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

The AMA also has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $7.4 million and $6.7 million in 2020 and 2019, respectively.

Prior to 2020, the AMA also maintained a non-qualified, unfunded supplemental pension plan for certain long-term employees. Participation in the plan was closed in 1994. The AMA recognized the liability in its consolidated statements of financial position. The accumulated benefit obligation and liability was eliminated in 2019 due to the pension plan termination. The supplemental pension plan termination was triggered by the termination of the AMA defined benefit pension plan and all distributions were finalized in 2019.

8. Postretirement health care benefits

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

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

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

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

	2020	2019
Benefit obligation at beginning of year	$ 115.4	$ 92.3
Service cost	1.5	1.6
Interest cost	3.2	4.2
Benefits paid	(2.9)	(4.1)
Participant contributions	1.3	1.2
Federal subsidy	0.1	0.1
Actuarial loss	1.9	20.1
Accrued postretirement benefit costs	$ 120.5	$ 115.4

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

	2020	2019
Actuarial losses	$ 27.8	$ 25.9
Prior service credits	(0.3)	(1.0)
	$ 27.5	$ 24.9

An estimated $0.4 million in prior service credits and $2 million of actuarial losses will be included as components of non-operating expense in 2021.

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

	2020	2019
Discount rate	2.5%	3.3%
Initial health care cost trend	5.64%	5.84%
Ultimate health care cost trend	4.5%	4.5%
Year that the rate reaches the ultimate trend rate	2038	2038

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

	2020	2019
Service cost	$ 1.5	$ 1.6
Interest cost	3.2	4.2
Amortization of prior service credit	(0.7)	(0.8)
Amortization of actuarial loss	-	0.5
	$ 4.0	$ 5.5

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

	2020	2019
Actuarial losses arising during period	$ (1.9)	$ (20.1)
Reclassification adjustment for recognition of actuarial losses	-	0.5
Reclassification adjustment for recognition of prior service credit	(0.7)	(0.8)
Change in unrestricted equity	$ (2.6)	$ (20.4)

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

	2020	2019
Discount rate	3.3%	4.3%
Initial health care cost trend	5.84%	6.03%

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

	1% increase	1% decrease
Effect on postretirement service and interest cost	$ 1.1	$ (0.8)
Effect on postretirement benefit obligation	$ 24.9	$ (19.5)

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

2021	$ 3.0
2022	3.2
2023	3.5
2024	3.6
2025	3.9
2026 – 2030	22.3

9. Income taxes

The provision for income taxes includes:

	2020	2019
Operating		
Current	$ 6.2	$ 6.2
Deferred	-	(2.1)
Valuation allowance	(0.2)	(0.3)
	6.0	3.8
Tax expense related to credits or charges to equity		
Deferred	0.2	0.9
	$ 6.2	$ 4.7

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

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

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

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

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

	2020	2019
Benefit plans and compensation	$ 7.7	$ 7.8
Other	(0.1)	-
	7.6	7.8
Valuation allowance	(2.7)	(2.9)
	$ 4.9	$ 4.9

Cash payments for income taxes were $4.9 million and $6.5 million in 2020 and 2019, respectively, net of refunds.

10. Leases

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

During 2020, AMA entered into new office space operating leases which resulted in establishing an additional $0.9 million in ROU assets and liability for the present value of future lease payments. The ROU assets will be amortized over the lives of the leases and the present value of the liability will be increased by interest cost and reduced by cash payments.

Operating lease costs totaled $10 million in both 2020 and 2019. Cash paid for amounts included in the measurement of lease liabilities totaled $12.8 million and $12.3 million in 2020 and 2019, respectively.

The weighted-average remaining lease term for operating leases is 8 years. The weighted-average discount rate used for operating leases is 5%.

The maturity of lease liabilities as of December 31, 2020:

2021	$ 13.1
2022	13.1
2023	12.8
2024	12.4
2025	12.5
2026 and beyond	41.0
Total lease payments	104.9
Less imputed interest	(19.2)
Present value of lease obligations	$ 85.7

11. Financial asset availability and liquidity

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

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

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

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2020
Financial assets	$ 889.2
Less assets unavailable for general expenditures:	
Restricted by donor with purpose restrictions	(0.1)
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(748.7)
Financial assets available to meet cash needs for general expenditures within one year	$ 140.4

	2019
Financial assets	$ 781.3
Less assets unavailable for general expenditures:	
Restricted by donor with purpose restrictions	(1.6)
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(662.7)
Financial assets available to meet cash needs for general expenditures within one year	$ 117.0

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

12. Contingencies

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

13. Subsequent events

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

For the year ended December 31, 2020, the AMA has evaluated all subsequent events through February 12, 2021, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

14. Functional expenses

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

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

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of goods sold and selling expense	$ -	$ 27.7	$ -	$ -	$ -	$ 1.6	$ 29.3
Compensation and benefits	5.5	58.1	-	63.5	84.2	6.1	217.4
Occupancy	0.5	5.7	-	6.7	6.7	1.5	21.1
Travel and meetings	0.1	0.8	-	1.8	1.3	0.1	4.1
Technology costs	1.8	9.6	-	4.4	10.1	0.1	26.0
Marketing and promotion	8.4	0.5	-	7.8	0.2	0.6	17.5
Professional services and consulting	0.4	4.9	0.2	16.1	4.3	4.2	30.1
Other operating expense	0.8	5.3	0.5	10.9	7.6	0.8	25.9
2020 total expense	**$ 17.5**	**$ 112.6**	**$ 0.7**	**$ 111.2**	**$ 114.4**	**$ 15.0**	**$ 371.4**
Cost of goods sold and selling expense	$ -	$ 27.8	$ -	$ -	$ -	$ -	$ 27.8
Compensation and benefits	5.3	55.0	-	59.0	78.1	7.1	204.5
Occupancy	0.5	5.7	-	6.7	7.4	1.5	21.8
Travel and meetings	0.2	3.4	-	7.3	6.6	0.5	18.0
Technology costs	1.4	10.5	-	4.7	10.0	0.1	26.7
Marketing and promotion	9.5	0.9	-	5.1	-	0.7	16.2
Professional services and consulting	0.1	3.7	0.2	12.5	4.0	3.5	24.0
Other operating expense	1.0	6.7	0.5	8.1	4.6	3.2	24.1
Pension termination expense	-	-	-	-	38.2	-	38.2
2019 total expense	**$ 18.0**	**$ 113.7**	**$ 0.7**	**$ 103.4**	**$ 148.9**	**$ 16.6**	**$ 401.3**

Independent auditors' report

The Board of Trustees of American Medical Association

We have audited the accompanying consolidated financial statements of the American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2020 and 2019, and the related consolidated statements of activities and of cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the American Medical Association and subsidiaries as of December 31, 2020 and 2019, and the results of its activities and changes in its equity and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP
Chicago, Illinois
February 12, 2021

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

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2020 and 2019 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

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

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 12, 2021

2020

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

From left:
Susan R. Bailey, MD
Gerald E. Harmon, MD
Patrice A. Harris, MD, MA
Bruce A. Scott, MD
Lisa Bohman Egbert, MD

Russ Kridel, MD
Bobby Mukkamala, MD
Jesse M. Ehrenfeld, MD, MPH
Sandra Adamson Fryhofer, MD
David H. Aizuss, MD

Grayson W. Armstrong, MD, MPH
Willarda V. Edwards, MD, MBA
Scott Ferguson, MD
Ilse R. Levin, DO, MPH & TM
Thomas J. Madejski, MD

Mario E. Motta, MD
Blake Elizabeth Murphy
Harris Pastides, PhD, MPH
Jack Resneck Jr., MD
Michael Suk; MD, JD, MPH, MBA

Willie Underwood III, MD, MSc, MPH
James L. Madara, MD

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-JUN-2021

Subject: AMA 2022 Dues

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee F

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

RECOMMENDATION

2022 Membership Year

The Board of Trustees recommends no change to the dues levels for 2022, that the following be adopted and that the remainder of this report be filed:

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

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-JUN-21

Subject: Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment (Resolution 606-NOV-20)

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee F

At the November 2020 Special Meeting, the House of Delegates referred Resolution 606, "Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment," to the Board of Trustees. Resolution 606, introduced by the International Academy of Independent Medical Evaluators, Maryland, and the American Academy of Physical Medicine and Rehabilitation, asked:

> That our American Medical Association support the adoption of the most current edition of the AMA Guides in all jurisdictions in order to provide fair and consistent impairment evaluations for patients and claimants including injured workers.

BACKGROUND OF THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT AND ADOPTION IN JURISDICTIONS

When a patient or worker suffers an injury or illness that results in permanent loss of function or of a body part, there is often a need to assess and quantify that loss in the form of an impairment rating. The workers' compensation and property casualty insurance systems rely on medical experts to provide impartial, consistent impairment ratings as an input in determining compensation and benefits. For over 60 years, the *AMA Guides® to the Evaluation of Permanent Impairment* (AMA Guides) have provided a reliable, repeatable measurement framework for quantifying permanent impairment (PI) and have been the trusted gold standard by physicians, patients and the legal and regulatory communities. The AMA Guides describe evaluation of PI across all body systems, including chapters that address cardiovascular, musculoskeletal, mental health and more. PI claims are far more common than fatalities and far more costly than other claims. They represent up to 70% of the $56 billion workers' compensation system.

In the United States, workers' compensation is governed at the state level. Over 40 states and several countries recognize the AMA Guides as the authority on evaluating PI and require raters in their jurisdiction (i.e., physicians and other qualified health care professionals) to use the AMA Guides. The AMA Guides have a clearly defined role in the workers' compensation landscape: to provide the best medical guidance in support of accurate and consistent impairment ratings. It is not the role of the AMA Guides to determine disability or compensation, which are social and economic decisions made by government authorities. In most states, an impairment rating calculated using the AMA Guides is only one factor in the determination of benefits for injured workers. Some states also use a Scheduled Loss system, which assigns dollar values to specific injuries such as loss of limb, digits or eyes. In the few states that use a pure "Scheduled Loss" approach the AMA Guides are not used.

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In the past, updates to the AMA Guides were published at inconsistent intervals and typically involved significant changes to methodology. They were last updated in 2008 when the sixth edition was released. Some states have elected to continue use of outdated medicine in older editions of the AMA Guides as a matter of convenience, ease of use, or political / economic expedience, despite advances in the science reflected in updated editions. For example, in some jurisdictions where the plaintiffs' bar was strong and well-organized, they resisted adoption of the sixth edition based on the belief that it lowered impairment ratings and thus compensation to their clients. The overall result manifests as a 'patchwork quilt' of states requiring use of different, and often outdated (up to 30 years), editions. Inconsistent application of the AMA Guides may increase the likelihood of inequitable compensation. Further, it creates unnecessary burden on physicians who evaluate impairment, especially those who practice in more than one jurisdiction.

This resolution is timely because the AMA has established a new editorial panel and process that support ongoing incremental improvement to the AMA Guides as new science becomes available. The first changes under this new process are scheduled for release at the beginning of April 2021. The panel and process are described later in this report, but historical context is valuable.

AMA MISSION AND POLICIES SUPPORT ADOPTION OF THE MOST CURRENT EDITION

Crucially, use of the most current medicine in the AMA Guides is aligned with the mission of the AMA, "*to promote the art and science of medicine and the betterment of public health.*" Existing policy "encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment" (H-365.981, "Workers' Compensation"). This policy supports uniformity and use of evidence-based medicine, in alignment with the intent of Resolution 606.

Several AMA policies provide further support for the AMA continuing its role in promoting physicians' and others' reliance on current medical evidence. For example, AMA ethical policy governing medical testimony recommends that such testimony "reflects current scientific thought and standards of care that have gained acceptance among peers in the relevant field" (9.7.1, "Medical Testimony"). With respect to education and training, "Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies; [and the AMA] Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities" (H-20.904, "HIV/AIDS Education and Training"). Current practices also extend to support for "The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate medical specialty societies are used to determine eligibility for sports participation" (H-470.971, "Athletic Preparticipation Examinations for Adolescents"). Using current scientific standards also is encouraged for patient safety: "Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means." (H-120.968, "Medication (Drug) Errors in Hospitals."

House of Delegates Considerations

Testimony in support of referral at the November 2020 Special Meeting reflected a few key considerations: 1) concern that the resolution was advocating for practice inconsistent with state laws; 2) the potential for legal challenges in jurisdictions; and 3) the possible implementation burden. Each of these concerns is addressed below.

The intent of Resolution 606 is not to advocate for or require physicians to use the AMA Guides in ways that would violate state law. Rather, the resolution should be clarified to outline that the AMA, along with state societies, advocate at the state or jurisdictional level to assist legislatures and/or regulators in consistently adopting the most current medicine to evaluate impairment. The AMA has a long history of providing guidance and advocacy assistance to states and supporting the use of the most current edition of the AMA Guides is consistent with that history. The AMA will continue to work with states to understand obstacles and to advocate why relying on the most current medicine to evaluate impairment is beneficial.

The concern with legal challenges may stem from each state's policy language. While some states' legislation calls for automatic adoption of the most current edition of the AMA Guides, this approach has been challenged. This is a complex area that has been taken to several state supreme courts with mixed results. Litigation in Pennsylvania (*Protz v. Workers' Compensation Appeal Board (Derry Area School District)*) was critical of how the state adopted impairment ratings that did not exist at the time the legislation was enacted, which constituted an inappropriate delegation of authority to the AMA. The AMA does not have any legal authority in a state, but the AMA can and does serve as an authority to encourage use of the most current medical standards in many contexts. The Kansas Supreme Court recently upheld a ruling that supported use of the most current edition of the AMA Guides, holding that the reference to the AMA Guides in the state statute does not make it unconstitutional because they are merely a guide and only serve as a starting point for an informed medical opinion.

SUPPORTING STATES' AND JURISDICTIONS' ADOPTION AND IMPLEMENTATION

In 2018 the AMA convened over 50 subject matter experts representing medicine, law, and government and received consistent feedback that the AMA Guides needed to be modernized in both content and delivery. Inconsistent adoption across jurisdictions was noted as a significant problem. Since then, the AMA has actively engaged with the stakeholder community. Through this engagement the AMA has found that obstacles rarely relate to the impairment rating described in the AMA Guides, and more frequently relate to different implementation challenges. To understand and address these challenges the AMA is collaborating with physicians, regulators, state and specialty medical societies.

Engaging the Community: AMA Guides Editorial Panel & Regulator Early Access Program

To incorporate the most current medicine the AMA appointed the AMA Guides Editorial Panel (Guides Panel) in 2019. With a transparent stakeholder-driven editorial process adapted from the approach used by the CPT® Editorial Panel, the Guides Panel considers proposed updates and revisions based on rigorous acceptance criteria, including supporting evidence, in a public forum and considers stakeholder feedback before approving any change proposal. The members and advisors serving on the Guides Panel bring diverse experiences and expertise across a broad range of medical topics. They were nominated by AMA Federation societies and other health care provider societies and selected by a team comprised of AMA management and physician leaders. Members do not advocate on behalf of their specialty or nominating organization.

To further understand and address implementation challenges the AMA convened the Regulator Early Access Program (EAP) – a quarterly focus group of executives and medical leaders from jurisdictional workers' compensation authorities. Based in part on this group's input the AMA has set an annual cadence for publication of Panel-approved updates. This update cycle allows for timely and incremental change that can be more easily reviewed by each jurisdiction prior to adoption. Significant changes are identified at least a year ahead of publication, enabling stakeholders to participate and prepare.

The AMA has also used the EAP to engage the regulatory community to better understand the benefits to the adoption of the most current edition of the AMA Guides. EAP members are helping the AMA to understand the different state legislative and regulatory needs to adopt the AMA Guides, which serves to inform the advocacy work proposed in Resolution 606. While seven states today require physicians to use updated content as it is released, many require legislative or regulatory action to achieve this. The AMA appreciates this dialogue and will continue to work with all key stakeholders in partnership with the Federation to support adoption of the most current edition of the AMA Guides.

Embracing Digital Delivery: Ed Hub and AMA Guides Digital

To meet the need for timely change education, the AMA is delivering change-focused modules with CME credit via the AMA Ed Hub™. In addition, targeted live virtual education sessions will be held to promote timely awareness among state workers' compensation medical leaders.

Launched in December 2020, AMA Guides Digital (available at www.amaguidesdigital.com) provides an integrated, nimble platform that enables users to easily navigate the AMA Guides sixth edition, new panel-approved updates beginning in April 2021, and 20 years of associated AMA Guides Newsletter articles. Guides Digital streamlines annual releases and provides anywhere anytime access to subscribers. These implementation resources directly address stakeholder needs.

CONCLUSION

The AMA enhances its ability to achieve its mission by advocating for use of the most current medicine to evaluate impairment in the AMA Guides. Using the most current medicine is the most effective way to provide fair and consistent impairment rating of patients. The transparent process by which the AMA Guides are updated enables stakeholders to be involved and informed. Anticipated changes are announced and communicated well before they become available and effective. Innovation through delivering AMA Guides in a digital format with supporting digital education further supports jurisdictions' adoption.

The intent of Resolution 606 is not to mandate that physicians use the most current AMA Guide regardless of state legal requirements. Rather, it supports the appropriate advocacy role and public health mission of the AMA. The referred resolution should be clarified to communicate that the AMA, along with state medical and specialty societies, advocate at the state or jurisdictional level to assist relevant government authorities in adopting the most current edition of the AMA Guides in support of the highest standards of medical science.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following policy be adopted in lieu of Resolution 606-Nov-20 and the remainder of this report be filed:

> Support for the Use of the Most Recent and Updated Edition of the *AMA Guides to the Evaluation of Permanent Impairment*.
>
> Our American Medical Association supports the adoption of the most current edition of the *AMA Guides to the Evaluation of Permanent Impairment* by all jurisdictions to provide fair and consistent impairment evaluations for patients and claimants including injured workers. (New HOD Policy)
>
> Fiscal Note: Minimal costs, not to exceed $5,000.

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-JUN-21

Subject: Joint Council Sunset Review of 2011 House Policies

Presented by: Madelyn E. Butler, MD, Chair, Council on Constitution and Bylaws
Shannon P. Pryor, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

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

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

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

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

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

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

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The Councils on Constitution and Bylaws and Long Range Planning and Development collaborated on this report, as they did the last time these policies were up for review and in the context of a project to once again examine the sunset review process. The Councils welcome feedback from the House on suggestions to improve the sunset review process.

The Councils note that there are several policies related to AMA elections due for sunset review in 2021, but these have been excluded as those policies are to be addressed by the Speakers' Task Force on Election Reform.

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
G-600.024	Representation of Medical Students and Residents in our AMA House	Our AMA supports the full participation of medical student and resident members of our AMA in the activities of the Association and in the policy processes of our AMA House of Delegates; and strongly encourages the delegation of each state association to have one resident delegate for each 1000 resident members of our AMA who are included in the base for determining the size of the state association's delegation.	Retain – this policy remains relevant.
G-600.090	Ancillary Meetings and Conferences of the House	The Speakers of our AMA House must be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees, Sections, and other groups that are part of the formal structure of our AMA can be scheduled in conjunction with Meetings of the House of Delegates.	Retain – this policy remains relevant.
G-605.080	Board Meetings	The policies on Board meetings are as follows: (1) The House holds the Board accountable for the proper oversight of our AMA, but not through (a) the recording and publication of individual votes on matters before the Board, or (b) open meetings, because neither will enhance the Board's deliberations and may hinder the Board's decision-making process. (2) Any AMA member in good standing shall be allowed full access to AMA Board of Trustees meetings upon advance notification to the Chair of the Board unless issues of personnel or sensitive nature require an executive session.	Retain – this policy remains relevant.
G-615.002	AMA Member Component Groups	A "Section" is a formal group of physicians or medical students directly involved in policymaking through a delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Each Section will continue to have representation in the House of Delegates. There will be two types of Sections, fixed and delineated. "Fixed Sections" will represent the natural cycles related to a physician’s career span. Since	Retain – this policy remains relevant.

		members of these groups would have limited opportunities for representation through their state/specialty's societies, the need for focused representation will be enduring. "Delineated Sections" will 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. Delineated Sections will have a single delegate and alternate delegate in the HOD, and will operate under Internal Operating Procedures approved by the Board of Trustees. Delineated Sections will be reviewed every 5 years by the Council on Long Range Planning, which will make recommendations through the Board of Trustees to the House of Delegates, for renewal of the Section, based on criteria adopted by the House. The review provision allows for fluidity in the Association's structure as the activities and impact of the member groups are routinely evaluated. An "advisory committee" is an entity whose activities relate to education and advocacy. An advisory committee will have a governing council and a direct reporting relationship to the BOT. Advisory committees, however, will not have representation in the HOD. Advisory committees will operate under a charter that will be subject to review and renewal by the BOT at least every four years. An "ad hoc committee" is a special committee, workgroup, or taskforce appointed by the BOT, the Speaker of the House, or the House of Delegates. These committees will operate for a specific purpose and for a prescribed period of time. A "caucus" is an informal group of physicians (from specialty and/or geographic medical groups or focused interest areas) who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports, candidates, and possible actions of the HOD. With the exception of AMA Section caucuses, these groups will not have a reporting relationship or resources allocated by the AMA.	
G-615.040	Opinions and Reports of CEJA	AMA policy on opinions and reports of CEJA includes the following: (1) CEJA will inform the House of Delegates of an ethical Opinion adopted by the Council by presenting the Opinion to the House. The Council: (a) will identify the Opinion	Retain – this policy remains relevant.

		as informational; (b) may provide a description or discussion of the underlying facts and circumstances leading to the adoption of the ethical Opinion, and also an explanation of the Opinion and the reasons for its adoption by the Council. This explanatory material is neither the opinion of the Council nor policy of the Association; (c) will identify one or more Principles of Medical Ethics that form the basis for issuing the ethical Opinion; and (d) will provide the text of the ethical Opinion. (2) The House's process for considering opinions of CEJA may include the following elements: (a) Opinions of CEJA will be placed on the consent calendar for informational reports, but may be withdrawn from the consent calendar on motion of any member of the House of Delegates and referred to a Reference Committee. (b) The members of the House may discuss an ethical Opinion fully in Reference Committee and on the floor of the House. (c) After concluding its discussion, the House shall file the Opinion. (d) The House may adopt a resolution requesting CEJA to reconsider or withdraw the Opinion. CEJA shall respond to such a request in due course, after reconsidering the issues presented. The Opinion of CEJA that responds to such a request will be considered as informational, and therefore shall be filed. (3) Reports of CEJA which respond to requests from the House or which make recommendations to the House may be adopted, not adopted, or referred, as may be appropriate. A report may not be amended, except for amendments that clarify the meaning of the report and only with the concurrence of the Council.	
G-615.105	Employed Physicians and the AMA	1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. 2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review,	Retain – this policy remains relevant.

		economic credentialing, and the denial of due process. 3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.	
G-625.010	AMA Mission and Vision	Mission: To promote the art and science of medicine and the betterment of public health. Core Values: (1) Leadership; (2) Excellence; and (3) Integrity and Ethical Behavior. Vision: To be an essential part of the professional life of every physician.	Retain – this policy remains relevant.
G-630.010	Executive Vice President	The qualifications, roles and responsibilities of the Executive Vice President are as follows: (1) The office of the Executive Vice President shall be filled, if possible, by a Doctor of Medicine who is an active member of our AMA at the time of his appointment and who possesses the necessary managerial qualifications. (2) The EVP shall clearly define and regularly evaluate roles and accountability of the corporate staff in adhering to clear guidelines on the limits of their decision-making authority and where to turn when confronted with issues beyond their scope of action: (a) The EVP should work with staff, the Board and the House to establish guidelines that differentiate between operational and policy issues, and identify to whom the staff should turn when they believe they are confronting an issue with policy implications. (b) These guidelines should be included both in the employee manual and a Board of Trustees Handbook. (c) These guidelines should be annually reviewed and updated, with the EVP leading the revision process. (d) Objectives in the performance appraisals of senior managers should be refocused to align with our AMA vision and bonus criteria should also be linked to the vision and the strategic plan. (e) Managers need to supervise work groups by establishing clear, measurable performance objectives and tasks for all staff and hold staff accountable. (3) The EVP shall evaluate staff structure and audit resources to ensure that our AMA is supported efficiently and effectively, consistent with the Strategic Plan approved by the House. As part of the evaluation of staff structure, the EVP should examine our AMA's member services strategy to ensure that the structure facilitates	Retain – this policy remains relevant.

		responsive and accurate responses to member queries. (4) Without suggesting that the current practice is or was in any way unauthorized, improper or illegal, the Executive Vice President will have the responsibility for hiring and firing the General Counsel following consultation with the Board of Trustees.	
G-630.021	Employment Agreements for Senior Executive Staff	Binding arbitration clauses should be contained in employment agreements for senior executive staff.	Retain – this policy remains relevant.
G-635.007	Electronic Application for Membership	1. Our AMA will provide all new online membership registrants with a post-transactional link to relevant state and county medical society web sites, where available. 2. Our AMA will implement a pre-transactional message and optional web site redirect mechanism to state society web sites for those medical students joining the AMA on-line from states with joint membership processing capabilities.	Retain – this policy remains relevant.
G-635.010	AMA Membership Strategy: General Approaches	Our AMA's general strategic approach on membership includes the following dimensions: (1) Our AMA and its component societies adopt the principle that membership value, as reflected in the physician's perception of quality relative to cost, drives the decision about membership. (2) Our AMA and its component societies adopt the principle that membership retention is as important an activity as recruitment, and that an organizational focus for those efforts should be developed. (3) The actions and directions of the Board of Trustees and Executive Vice President, with regard to membership recruitment, retention, and satisfaction, should become the top priorities of every AMA staff member, at all levels of the organization, and of all the Association's elected leadership. (4) Our AMA seeks innovative means to change its governance and structure to better align membership and representation for the purpose of meeting member needs and unifying the House of Medicine. (5) Our AMA will explore new avenues to increase member participation in the activities and governance of our AMA. (6) Our AMA shall continue to utilize pilot programs to measure the success of innovative membership recruitment and retention activities.	Retain – this policy remains relevant.

		(7) Our AMA will increase its staff and administrative efforts to become more of a local presence in the various regions of the United States.	
G-635.024	AMA Membership and Physicians on AMA Editorial Boards	Our AMA encourages all physicians serving on the editorial boards of AMA-published journals to become members of our AMA.	Retain – this policy remains relevant.
G-640.010	Guidelines for Representation of the AMA	Guidelines for the representation of our AMA include: (1) Our AMA directs that any individual who is publicly representing our AMA shall not present positions in conflict with established AMA policy; and (2) When appropriate, AMA public statements note that AMA policy is formulated by the House of Delegates, whose members represent approximately 90 percent of American physicians, even though a smaller percentage of eligible physicians are currently dues-paying members.	Retain – this policy remains relevant.
G-640.020	Political Action Committees and Contributions	Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries.	Retain – this policy remains relevant.

G-620.060	Enhancing the Value of Membership in Organized Medicine	The perspective of our AMA House on enhancing the value of membership in organized medicine includes the following: (1) The House adopts the goal of improving Federation performance as a whole; (2) The House supports efforts to improve the Federation's business processes by implementing a ~~to improve the Federation's business processes by implementing to include a new member early recognition and retention system and~~ consolidated billing and application process; (3) The House supports the redesign of Federation products and pricing to increase overall appeal and thus recruit additional members and improve retention; (4) The House believes that the Federation should work together to leverage each organization's core competencies; (5) The House encourages the testing of different strategic and operational collaborative arrangements at many sites and the use of these to improve Federation membership, pricing, and member service; (6) The House encourages state medical associations and national medical specialty societies to review the composition of their AMA delegations; (7) The House believes it is important to promote resident physician membership in national medical specialty societies; (8) The House urges all county and state societies to implement a simple transfer of membership procedure to permit uninterrupted membership in organized medicine for physicians who relocate at any time during their careers, with such procedure containing the flexibility to permit resident AMA members to become regular state and county members through the transfer process; and (9) ~~G-635.023, AMA Support for the AMA Alliance~~ Our AMA encourages its members to urge their spouses and their partners to become members of the AMA Alliance and their respective Alliances. The House encourages medical associations and societies to support the membership efforts of the Alliance, particularly if dual membership billing is utilized, and, with the state and county associations, supports and acknowledges the efforts of our AMA Alliance and state and county medical alliances, whenever it is deemed possible and appropriate.	Retain as editorially amended [new member recognition and retention system has been accomplished] and consolidate with G-635.023

G-630.070	International Strategy	1. Our AMA recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship. ~~H-250.998~~ 2. The AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations. ~~H-250.992~~ 3. The AMA: (~~1~~a) continues to support the World Health Organization as an institution; (~~2~~b) advocates full funding as understood by the United States Government for the World Health Organization; (~~3~~c) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4d) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. ~~H-250.999~~ 4. Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO. ~~H-250.991~~ 5. The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. ~~H-250.993~~ 6. The AMA will: (~~1~~a) continue to focus its international activities on and through organizations that are multinational in scope; (~~2~~b) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (~~3~~c) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (~~4~~d) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (~~5~~e) work with the AAMC to ensure that international electives provide measur~~a~~able and safe educational experiences for	Retain and consolidate with H-250.998, H-250.992 and H-250.991, H-250.993, H-250.986, H-250.999

		medical students, including appropriate learning objectives and assessment methods; and (~~6~~f) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives. ~~H-250.986~~ 7. Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.	
G-610.031	Creation of an AMA Election Reform Committee	Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.	Rescind – Task force members were appointed as directed; Speakers' Report: Task Force on Election Reform was presented at I-19; and Election Task Force is assessing the entirety of our election process, with recommendations forthcoming.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(JUN-21)

Introduced by: Mississippi, New Jersey, Puerto Rico, South Carolina, Oklahoma

Subject: $100 Member Annual Dues Payment Through 2023

Referred to: Reference Committee F

Whereas, Many physician practices have struggled during the unprecedented COVID-19 pandemic with economic viability over the past year as a result of decreased revenue and increased expenses due to the pandemic; and

Whereas, Reimbursement cuts continue to loom on the horizon for physician practices; and

Whereas, In the face of decreasing patient volume, increasing expenses, and reimbursement cuts, physicians have had to make difficult choices to maintain their practices; and

Whereas, Many physicians have elected not to renew their memberships in their professional organizations, including the American Medical Association as evidenced by the fact that our AMA has seen a drop in actively practicing physician membership as noted in the report provided to us in January 2021; and

Whereas, Our AMA is the most important voice representing America's doctors across all specialties and all stages and modes of practice; and

Whereas, That voice is too important to allow a declining membership to weaken our effectiveness; and

Whereas, Based on 2019 data, membership dues revenue provides less than 8% of the total revenue (less that 7% in net revenue) to our annual AMA budget; and

Whereas, Our AMA has an opportunity to not only increase our membership but also recognize the heroic sacrifice that our existing AMA members have made in responding to the pandemic; therefore be it

RESOLVED, That our American Medical Association adjust dues to $100 per year for a trial period of two years for actively practicing physicians and senior physicians. (Directive to Take Action)

Fiscal Note: Cost to implement this resolution is $20.9 million annually.

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

During the pandemic crisis, many physician practices have struggled because of decreasing revenue and increasing expenses. Many physicians have had to make difficult choices including the renewal of memberships in professional organizations such as the American Medical Association. The AMA is the leading voice of America's doctors and this voice should not be muzzled because members and potential members cannot afford the dues. We feel this 2 year time limited resolution should be brought before the House of Delegates urgently to make sure that physicians are taken care of during their time of need.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(JUN-21)

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 it is widely acknowledged that medical care and decision making at the end-of-life are best managed both ethically and medically with the use 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 decisions, concomitant with limited or no access to their loved ones at the bedside, which has exponentially increased stress on physicians and others caring for critically ill patients; and

Whereas, The recent resurgence in COVID infections, hospitalizations and deaths makes this a continuing high priority issue under the J-21 HOD Prioritization Matrix; and

Whereas, Advance directives specify the extent of care a person wishes when they are unable to make medical decisions for themselves and often, due to hospital isolation requirements under COVID-19, no one is available to speak for them; and

Whereas, The use of advance directives has been shown to bring comfort, closure, peace-of-mind, and family support to patients and to physicians providing critical and terminal care, while also reducing healthcare costs; 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, and MyDirectives, including local medical organizations, AARP, state governments, faith-based groups, hospitals, and others, yet are underutilized; and

Whereas, AMA Code of Ethics Opinion 5.1, “Advance Care Planning,” encourages physicians and patients to plan in advance for decisions about care in the event of a life-threatening illness or injury, emphasizes that such discussions should not begin only after a potentially fatal illness or injury has befallen a patient, and urges that physicians should regularly encourage all patients, regardless of age or health status to consider these issues, periodically review with them their goals, preferences, and chosen decision maker, and include notes from these conversations in medical records; and

Whereas, AMA Code of Ethics Opinion 5.2, “Advance Directives,” discusses the importance of documenting advance care planning discussions; and

Whereas, Despite ethical directives, studies show that only about 37% of Americans have completed advance directives and physicians have also been shown 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, bringing this concern squarely into one of the highest priority areas for our AMA; 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 advance care planning has still not become a routine part of medical practice; and despite past AMA recommendations and ethical guidelines, Advance Directive forms are not yet fully integrated as part of the medical record; and

Whereas, Advance directives, when not completed by patients or when not available to providers because they are not included in the medical record, may not be found, considered by, or honored by providers, prompting ethical concerns[1] and moral distress[4]; therefore be it

RESOLVED, That our American Medical Association begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage all primary care physicians to include advance care planning as a routine part of their adult patient care protocols, and also to include advance directive documentation in patients' medical records as a suggested standard health maintenance practice (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions (Directive to Take Action); and be it further

RESOLVED, That our AMA actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day. (New HOD Policy)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents a high, but not a top priority issue for our AMA. This resolution affects all physicians and patients, with a greater potential impact on senior physicians and patients who have increased vulnerability both to infection and death from Covid. Additionally, lack of AD has disproportionately affected underrepresented or disadvantaged patient populations.

As we near 600,000 deaths from Covid-19 (up to 63% of whom may not have had AD) with frontline colleagues daily facing the distress of making life and death decisions for patients unable to speak for themselves (and pandemic policies preventing family members at the bedside) there is a high likelihood of ongoing negative impact if we continue to overlook this issue, and do not act now to encourage active modeling and facilitation of creation of AD. Modeling healthful behaviors by physicians is consistent with our mission and strategic plan. The resolution calls for action that is likely to have meaningful impact, and requires a more proactive approach, incorporating the rationale and evidence for more active promotion of existing policy or significant modification of current policy, so as to immediately begin to address this important issue.

AMA has prior policy on this issue, but an important gap exists in that there has not been evidence of active implementation of existing policy. An AMA resolution is one of the most appropriate avenues to address this issue.

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RELEVANT AMA POLICY

H-85.950 - Support of a National Registry for Advance Directives
H-85.956 - Educating Physicians About Advance Care Planning
H-390.916 - Payment for Patient Counseling Regarding Advance Care Planning
D-140.968 - Standardized Advance Directives
E-5.1 Code of Medical Ethics - Advance Care Planning
E-5.2 Code of Medical Ethics - Advance Directives

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(JUN-21)

Introduced by: American Association of Public Health Physicians

Subject: AMA Urges Health & Life Insurers to Divest From Investments in Fossil Fuels

Referred to: Reference Committee F

Whereas, Our AMA recognizes the urgent, ongoing health threats posed to our patients by global climate change,[1] which on its current trajectory is likely to far exceed the health impacts of COVID-19 and HIV combined; and

Whereas, Our AMA "recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes"[1]; and

Whereas, In 2018, our AMA pledged that, "our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels," with companion policy to "support efforts of physicians and other health professional associations to proceed with divestment"[2]; and

Whereas, In the past, many health and life insurance companies followed the example of the AMA by divesting from tobacco companies because the tobacco industry's products and marketing strategies so clearly damage human health; and

Whereas, Moody's Investors Service warned investors in 2017 that the oil and gas industry faces significant credit risks due to the world's ongoing transition away from fossil fuel[3]; and

Whereas, The oil and gas industry stock prices have been the poorest performing sector of world stock markets since 2008, a period during which the prices of most other sectors have risen dramatically; and

Whereas, The top 10 U.S. health insurers, ranked by U.S. market share and for whom there are publicly disclosed fossil fuel investment data, have invested nearly $24 billion in fossil fuels companies[4]; and

Whereas, Collectively, the largest nineteen health or life insurance companies have declared investments of more than $183 billion in the fossil fuel industry[4]; therefore be it

RESOLVED That our American Medical Association declare that climate change is an urgent public health emergency, and call upon all governments, organizations, and individuals to work to avert catastrophe (Directive to Take Action); and be it further

RESOLVED, That our AMA urge all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (New HOD Policy); and be it further

RESOLVED, That our AMA actively inform the largest health insurance and life insurance companies, and the associations representing those companies, about AMA policies concerned with climate change and with fossil fuel divestment, and will encourage such companies and associations to take similar actions (Directive to Take Action); and be it further

RESOLVED, That our AMA report the status of AMA's implementation of our 2018 fossil fuels divestment policies (D-135.969 and H-135.921), as well as the implementation of this resolution, to the 2021 Interim Meeting of the House of Delegates. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This is a Top Priority Resolution according to the AMA Prioritization Matrix:
• Affects most or all physicians and/or their patients: Climate change is the most important public health issue facing the world in 21st Century with already a disproportionate share of the health impacts being faced by economically disadvantaged populations. The resulting health and political chaos, already involving regional wars and perhaps worse, will not spare any populations of substantial size in the world.
• Not acting at this meeting is likely to have a seriously deleterious impact: Each year that the world fails to take meaningful action is aggravating the health impacts of climate change. Our AMA has a unique and influential voice within the health care and Public Health sectors. We must use this voice, urgently, at each opportunity.
• Consistent with our mission and strategic plan: The betterment of public health requires protection of the human environment against humanity's most urgent threats.
• Calls for near-term important action and requires new policy to implement: Climate disruption is urgent. We have opportunity to use our AMA's voice now. That voice will be influential.
• No current policy exists on this topic, and it is an important issue on which to have policy: Our AMA's existing policy applies to our AMA, to its subsidiaries, and to health professionals and associations. Health and life insurers have very large investments, about which our AMA has no current policy.
• AMA action or policy statement will have a positive impact: AMA's voice, applied to insurers and in the public arena, is likely to be highly influential.
• AMA is most appropriate to tackle this issue, i.e., issue is not better handled by a specialty society or other group/organization: Because of its longstanding advocacy for the public interest and public health, our AMA has a uniquely credible, and uniquely influential, voice on this topic. The special relationships of physicians with the health insurance industry make it important that AMA speak out on this aspect of the issue of climate change. Success in this area will serve as an example to others, and will reduce the "moral hazard" in which those who profit from climate change stay silent when they should speak up.

References:
1. AMA Policy H-135.938, "Global Climate Change and Human Health", accessed May 12, 2021.
2. AMA Policies D-135.969 & H-135.921, "AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies", accessed May 12, 2021.

3. https://www.moodys.com/research/Moodys-Significant-credit-risks-arise-for-oil-and-gas-industry--PR_365728 , Accessed April 30, 2021.
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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
Citation: BOT Rep. 34, A-18;

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

1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
Citation: BOT Rep. 34, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(JUN-21)

Introduced by: Jerry P. Abraham, MD, Delegate

Subject: Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

Referred to: Reference Committee F

Whereas, The Lancet Countdown on health and climate change has warned that "A rapidly changing climate has dire implications for every aspect of human life, exposing vulnerable populations to extremes of weather, altering patterns of infectious disease, and compromising food security, safe drinking water, and clean air"[1] earning it the title of the "greatest public health challenge of the 21st century";[2] and

Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition *alone*[3], without factoring in the myriad other ways that climate change acts as a health risk multiplier; and

Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable to the particulate matter (PM) 2.5 of planet-warming fossil-fuels, constituting nearly 18% of premature deaths[4]; and

Whereas, Burning fossil fuels and other greenhouse gas (GHG) emissions have already caused a rise in the global average temperature of 1.2°C and our changing climate is already producing considerable shifts in the underlying social and environmental determinants of health at the global level[5]; and

Whereas, Across all climate risks, children, older adults, low-income communities, outdoor workers[6] some communities of color, communities disproportionately burdened by poor environmental quality[7], some communities in the rural Southeastern United States[8] and those experiencing discrimination are disproportionately affected by extreme weather and climate events, partially because they are often excluded in planning processes,[9] and

Whereas, Many climate change mitigation interventions have immediate local air quality benefits--among others-- and thus immediate health co-benefits[10] which is part of why near-term benefits outweigh climate solution costs in many areas;[11] and

Whereas, According to the latest available science, to limit warming to 1.5°C and achieve the Paris Agreement goals would require global greenhouse gas (GHG) emissions to have peaked by 2020 and be reduced to zero by around 2050[12], thus we are in a vanishing window of opportunity for meaningful action; and

Whereas, Physicians are uniquely trusted messengers[13], with a unique responsibility to advocate politically for policies to safeguard health in the face of any public health crisis--whether the COVID-19 pandemic, the need for tobacco and firearm regulation or the climate crisis--in order to build social will for science-based policy action; and

Whereas, Our AMA House of Delegates has adopted multiple policies addressing climate change (H-135.919, H-135.938, H-135.977, H-135.923, D-135.968,D-135.969, H-135.973), but these policies fall short of coordinating strategic physician advocacy leadership on the scale necessary for such a health crisis; and

Whereas, In the face of the existential threat that the climate crisis poses, these policies have not been leveraged to fulfill our AMA's *Declaration of Professional Responsibility (H-140.900)* in which '*We, the members of the world community of physicians, solemnly commit ourselves to 'Medicine's Social Contract with Humanity*' in order to continue to earn society's trust in the healing profession, by, among other oaths, promising that we will '*Educate the public and polity about present and future threats to the health of humanity*', and '*Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being*;' and

Whereas, Our AMA has no identified longitudinal body or center for coordinating and centralizing the Association's efforts to address climate change which the WHO calls "the greatest threat to global health in the 21st century;"[14] therefore be it

RESOLVED, That our American Medical Association establish an internal, climate crisis-focused center for the purpose of fulfilling our social contract with humanity in this global public health crisis by determining the highest-yield advocacy and leadership opportunities for physicians, and for coordinating, strengthening and centralizing our AMA's efforts toward advocating for an equitable and inclusive transition to a net-zero carbon society by 2050. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution sits at the intersection of climate change, human health, and social justice. The authors and contributors believe this resolution needs to be passed this summer because with the current administration, there is a critical political window to enact change in the climate policy and environmental justice spaces-- and our AMA is not fully-prepared to lead on this public health crisis. Biden's team has listed climate change as one of four top priorities this year and a number of climate-focused bills have already been introduced in the 117th Congress. NASA analyses show in no uncertain terms that the Earth's average temperature in *2020 tied with 2016 as the warmest year on record. The last seven years have been the warmest seven years on record*. An accelerating, unstable climate is incompatible with human health and safety.

This year also marks the 26th UN Climate Change Conference (AKA climate COP), in November in Glasgow, Scotland. This year's COP26 is anticipated to be the most important international climate summit since the Paris Agreement made at COP21 in 2015. COVID-19 has demonstrated the morbidity and mortality costs paid when politics ignore what the science clearly calls for, and the critical leadership of physicians in the face of global public health crises. To fulfill our social contract with humanity, we, as America's physicians must organize our AMA's advocacy on climate to lead for public health-- now is the time.

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RELEVANT AMA POLICY

H-135.919 Climate Change Education Across the Medical Education Continuum

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education. [Res. 302, A-19]

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on

environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19]

H-135.977Global Climate Change - The "Greenhouse Effect"
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population. [CSA Rep. E, A-89Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. [Res. 924, I-16Reaffirmation: I-19]

D-135.968 Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership
Our AMA will continue to explore environmentally sustainable practices for JAMA distribution. [BOT Rep. 8, I-19]

D-135.969 AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies
Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels. [BOT Rep. 34, A-18]

H-135.973 Stewardship of the Environment
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects

resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. [CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(JUN-21)

Introduced by: Medical Student Section

Subject: Amending G-630.140 Lodging, Meeting Venues, and Social Functions

Referred to: Reference Committee F

Whereas, The seven regions of the AMA Medical Student Section (MSS) are a primary link between the national initiatives of the MSS and student members at the section level; and

Whereas, In the fall of 2018, our AMA started a pilot program hosting individual, geographically-separate MSS Region Meetings with the goal of strengthening Region cohesion, fostering inter-student mentorship, and enriching the student experience; and

Whereas, The pilot included geographically separate MSS Region Meetings hosted in each individual Region, which stemmed from feedback received from 2015 to 2018, when all Region meetings were held simultaneously, in conjunction with Advocacy Day in Washington, DC; and

Whereas, During this period of time, MSS leadership and staff received reports that students had difficulty attending Region meetings due to financial constraints on travel to Washington, DC and the inflexibility of holding all Region meetings on one day; and

Whereas, Through the Region Meetings pilot program, six Regions planned and held Region Meetings between January and February 2019; and

Whereas, Region 3 was limited in organizing their Region Meeting due to AMA Policy G-630.140 Lodging, Meeting Venues, and Social Functions, which was amended at A-17 to ensure that future AMA-organized or -sponsored meetings do not take place in towns, cities, counties, or states with discriminatory policies; and

Whereas, G-630.140 with the amendment currently restricts the AMA from organizing or sponsoring meetings in Alabama, Kansas, Kentucky, Mississippi, North Carolina, Oklahoma, South Dakota, Tennessee, and Texas; and

Whereas, Based on the list of restricted states, Region 3 cannot hold Region meetings in four of their six states (Kansas, Mississippi, Oklahoma, Texas), and the two remaining states (Arkansas, Louisiana) are not centrally located; and

Whereas, Region 3 held their Region Meeting in Louisiana, and received multiple reports from students about the difficulty of attending the Region Meeting based on travel distance; and

Whereas, Based on the list of restricted states, Region 1 cannot hold meetings in South Dakota, Region 4 cannot hold meetings in three of their six states (Alabama, North Carolina, Tennessee), and Region 5 cannot hold meetings in Kentucky; and

Whereas, The AMA Board of Trustees in conjunction with AMA legal counsel determined that Region Meetings do not qualify for exemption from G-630.140 as a special circumstance without further amendment of the policy; and

Whereas, While G-630.140 should continue to be enforced for national meetings such as Annual and Interim to uphold the AMA's commitment to non-discrimination, enforcement for Region Meetings reduces participation in small gatherings for students who are financially and temporally limited in their ability to travel, especially in disproportionately affected Regions; and

Whereas, The MSS is the only section that has thus far been affected by the amendment to G-630.140, making it the most appropriate body to bring this concern to the HOD; therefore be it

RESOLVED, That our American Medical Association amend AMA policy G-630.140, "Lodging, Meeting Venues, and Social Functions," by addition to read as follows:

LODGING, MEETING VENUES, AND SOCIAL FUNCTIONS, G-630.140

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold <u>national</u> meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution has been pending since June 2019, and its adoption is paramount for our delegation's local meetings. Our leadership has already engaged in conversations with our AMA Board of Trustees and AMA legal counsel, and were told that a revision to existing policy is required. It addresses the issue of an undue logistical and financial burden for several MSS Regions regarding travel to their Regional Meetings, stemming from current policy that prohibits hosting AMA-sponsored meetings in states with discriminatory laws

As a specific example, Region 3 of the AMA-MSS consists of 6 states, 4 of which are prohibited from holding meetings. Texas is one such state that is prohibited from hosting the meeting, despite being centrally located and home to 90% of the Region 3 membership. We believe that this amendment to existing policy strikes a balance between ensuring that the AMA as an organization stands against discriminatory policies, while enabling its members in smaller gatherings to continue to collaborate and organize, often times working against these same policies. The impact of small gatherings, such as Region meetings, on the repeal of discriminatory policies is much lower and often negligible, while the impact of having to travel further has a significant impact on the ability of students to attend meetings, for both reasons of funding and time spent in travel. Many of these students are strong advocates and will progress to become physician advocates, so we believe it important to foster their development.

RELEVANT AMA POLICY

Lodging, Meeting Venues, and Social Functions G-630.140
1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close
proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. BOT Rep. 17, A-17

Meeting Calendar and Locations G-600.130
AMA policy on the meeting calendar for the House includes the following: (1) Our AMA should make reasonable efforts to avoid scheduling future Annual Meetings that conflict with Father's Day weekend; (2) The Interim Meeting of the House of Delegates will be held in the second or third week in November; and (3) Our AMA supports scheduling more meetings in Washington, DC, specifically including Interim Meetings of the House on a rotating schedule as frequently as practicable. Our AMA believes, however, that it would not be financially prudent to hold all Interim Meetings in Washington, DC, nor would such a decision be equitable for other regions of the country.
BOT Rep. I, I-90; BOT Rep. 36, A-94; BOT Rep. 1, I-98; Modified: Speakers Advisory Committee Rep., A-99; Reaffirmed: Sunset Report, I-00; Resolution 609, A-01; Consolidated: CLRPD Rep. 3, I-01; Appended: Res. 610, A-02; Appended: Res. 609, A-04; Reaffirmed in lieu of Res. 609, A-06; CC&B Rep. 3, I-08; CCB/CLRPD Rep. 3, A-12; Modified: Res. 606, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(JUN-21)

Introduced by: Medical Student Section

Subject: AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations

Referred to: Reference Committee F

Whereas, Given the 100,120 reported firearm injuries and 36,383 reported firearm deaths in the United States each year on average and the significant financial burden that the gun violence epidemic poses on society, the AMA recognizes that gun violence represents a public health crisis in our country (D-145.995)[1-3]; and

Whereas, Laws that required a heightened showing of suitability for concealed carry, such as universal background checks and "may issue" laws, and laws that prohibit gun possession by people convicted of violent misdemeanors, were found to be associated with lower firearm homicide rates[4]; and

Whereas, The AMA has adopted several policies demonstrating support for increased regulation of firearm sales as well as research into the efficacy of different regulations (H-145.997, H-145.975, H-145.972, H-145.996, H-145.985)[5]; and

Whereas, The Dickey Amendment currently prevents the Centers for Disease Control and Prevention from using funding to advocate for and promote gun control, but does not place an explicit ban on gun violence research[7]; and

Whereas, The AMA political action committee continues to make donations to politicians who vote in opposition to aforementioned firearm regulation policies, donating $54,889 combined to 17 candidates in 2018 who were also financed by the National Rifle Association and received A-ratings from the National Rifle Association [6,8-9]; and

Whereas, Political ratings are used to measure a politician's alignment with the mission of the National Rifle Association and overall support for firearm regulation[9,10]; and

Whereas, 141 Congress members received donations from both physician organization PACs and the NRA PVF in 2018, and with one exception, sitting NRA-backed congress members who received funds from physician organizations voted on policies not in keeping with physician recommendations, including opposing legislation to require universal background checks, and to prevent individuals prohibited from owning a firearm from utilizing shooting ranges[8,10]; and

Whereas, The National Rifle Association Institute for Legislative Action denies the existence of the "gun show loophole," opposes expanding firearm background check systems, and opposes firearm registration, contradicting AMA policy supporting expansion of background checks and registration of firearms (H-145.996)[11]; and

Whereas, The AMA has called upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries (G-640.020); therefore be it

RESOLVED, That our American Medical Association amend policy G-640.020 by addition to read as follows:

G-640.020 – POLITICAL ACTION COMMITTEES AND CONTRIBUTIONS
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; ~~and~~ (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Gun violence has been a priority for our AMA for many years. Our delegation continues to believe that gun violence is an issue that needs to be addressed with transparency in the United States. Gun Violence in recent years has become a public health emergency as we have seen increase in mass shootings and police involved shootings. It in imperial that AMA takes a stand on this issue and lobby for research to be done on the effects of gun violence. Furthermore, the language of this resolution specifically and intentionally models after the language of existing clause(8).

References:

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6. Schuur, J. D., Decker, H., & Baker, O. (2019). Association of Physician Organization–Affiliated Political Action Committee Contributions With US House of Representatives and Senate Candidates' Stances on Firearm Regulation. JAMA network open, 2(2), e187831-e187831.
7. Rostron, A. (2018). The Dickey Amendment on federal funding for research on gun violence: a legal dissection.
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10. 2018 Congressional Scorecard. NSSF Firearms Industry Trade Association. https://nssf.org/firearms-industry-releases-2018-midterm-election-scorecard/. Accessed March 22, 2019.
11. National Rifle Association Institute for Legislative Action: Background Checks | NICS. https://www.nraila.org/get-the-facts/background-checks-nics/. Accessed August 25, 2019.

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban. (Res. 1011, A-16, Reaffirmation: A-18, Reaffirmation: I-18)

Political Action Committees and Contributions G-640.020
Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care;
(2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process;
(3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process;
(4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates;
(5) Encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions;
(6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs;
(7) Will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; and
(8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries. (BOT Rep. II and Res. 119, I-83, Res. 175, A-88, Reaffirmed: Sunset Report, I-98, Sub. Res. 610, A-99, Res. 610, I-00, Consolidated: CLRPD Rep. 3, I-01, Modified: CCB Rep. 2, A-11)

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms. (CSA Rep. A, I-87, Reaffirmed: BOT Rep. 50, I-93, Appended: Res. 403, I-99, Reaffirmation: A-07, Reaffirmation: A-13, Appended: Res. 921, I-13, Reaffirmed: CSAPH Rep. 04, A-18, Reaffirmation: A-18, Reaffirmation: I-18, Appended: Res. 405, A-19)

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Sub. Res. 221, A-13, Appended: Res. 416, A-14, Reaffirmed: Res. 426, A-16, Reaffirmed: BOT Rep. 28, A-18, Reaffirmation: A-18, Modified: CSAPH Rep. 4, A-18, Reaffirmation: I-18)

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (CSAPH Rep. 4, A-18, Reaffirmed: BOT Rep. 11, I-18)

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored. (Res. 140, I-87, Reaffirmed: BOT Rep. 8, I-93, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmed: CSAPH Rep. 1, A-15, Modified: BOT Rep. 12, A-16, Appended: Res. 433, A-18, Reaffirmation: I-18, Modified: BOT Rep 11, I-18)

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths. (BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmation A-14, Appended: Res. 427, A-18, Reaffirmation: A-18, Modified: Res. 244, A-18)

Reference Committee G

BOT Report(s)

09 Preservation of the Patient-Physician Relationship
13 Amending the AMA's Medical Staff Rights and Responsibilities

CMS Report(s)

01* Council on Medical Service's Sunset Review of 2011 House Policies
03* Universal Basic Income Pilot Studies
04* Promoting Accountability in Prior Authorization
05* Medical Center Patient Transfer Policies
06* Urgent Care Centers
09* Addressing Payment in Delivery in Rural Hospitals

Resolution(s)

701 Physician Burnout is an OSHA Issue
702 Addressing Inflammatory and Untruthful Online Ratings
703 Employed Physician Contracts
704 Eliminating Claims Data for Measuring Physician and Hospital Quality
705* Improving the Prior Authorization Process
706* Prevent Medicare Advantage Plans from Limiting Care
707* Financial Incentives for Patients to Switch Treatments
708* Medicare Advantage Record Requests

** Contained in the Handbook Addendum*

REPORT 09 OF THE BOARD OF TRUSTEES (June-2021)
Preservation of the Patient-Physician Relationship
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting Resolution 703-A-19, "Preservation of the Patient-Physician Relationship," was introduced by the Organized Medical Staff Section and referred by the House of Delegates (HOD) for report back at the 2020 Interim Meeting. The 2020 Interim Meeting was replaced with a Special Meeting of the HOD due to restrictions resulting from the COVID-19 pandemic. This report was not presented during the Special Meeting so is now presented to the HOD at the June 2021 Special Meeting. The resolution asks the American Medical Association (AMA) to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, and to identify health care work environment factors that impact a physician's ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter.

Many factors contribute to the patient-physician relationship, including the use of electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-JUN-21

Subject: Preservation of the Patient-Physician Relationship

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee G

INTRODUCTION

At the 2019 Annual Meeting Resolution 703-A-19, "Preservation of the Patient-Physician Relationship," was introduced by the Organized Medical Staff Section and referred by the House of Delegates (HOD) for report back. The resolution asks our American Medical Association (AMA) to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, and to identify health care work environment factors that impact a physician's ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter.

This report discusses factors that contribute to patient-physician relationships and when those factors can detract from the physician's ability to provide high quality care or result in barriers to communication that can threaten the patient-physician relationship. The AMA has dedicated significant resources and effort to identifying and addressing the barriers to patient care and effective patient-physician relationships, including the use of technology, documentation requirements, prior authorization, and other work environment factors. This report will in part describe those efforts and relevant outcomes.

BACKGROUND

The relationship between a patient and their physician is sacred. It requires trust, honesty, and communication. As the healthcare industry has changed in recent decades, so have external factors and internal dynamics that influence the patient-physician relationship. Both the patient's and physician's roles and experiences have evolved, as well as their perceptions and expectations of the communication and relationship with each other. Many factors contribute to the patient-physician relationship, including electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.

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AMA POLICY

The AMA *Code of Medical Ethics* provides a definition of the patient-physician relationship that exemplifies the spirit of this resolution. "The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare" (*Code of Medical Ethics* 1.1.1, "Patient-Physician Relationships").

Health care technology has become integral to the practice of medicine and has improved many aspects of patient care and the patient-physician relationship. The AMA recognizes the important role technology has in modern health care and has established multiple policies to reflect this. For example, the AMA supports the establishment of coverage, payment, and financial incentive mechanisms to support the use of mobile health applications and associated devices, trackers, and sensors by patients, physicians and other providers that support the establishment or continuation of a valid patient-physician relationship (Policy H-480.943, "Integration of Mobile Health Applications and Devices into Practice"). AMA policies support telemedicine as a mechanism to deliver patient care and advocates for the widespread adoption of telehealth services in the practice of medicine (Policy D-480.965, "Reimbursement for Telehealth" and Policy D-480.963, "COVID-19 Emergency and Expanded Telemedicine Regulations"). The AMA *Code of Medical Ethics* also make it clear that these technologies should not compromise or interfere with the patient-physician relationship (AMA Code of Medical Ethics 1.2.12, "Ethical Practice in Telemedicine). It is AMA policy that new communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. The AMA provides detailed guidelines for the appropriate and optimal use of email and text messages for communicating with patients (Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging"). The AMA *Code of Medical Ethics* also provides guidance for the ethical and professional use of email and text message communications (Opinion 2.3.1, "Electronic Communication with Patients").

The AMA supports protecting the patient-physician relationship by advocating for the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements (Policy H-165.837, "Protecting the Patient-Physician Relationship"). The AMA also supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization, or specialty consultation (Policy H-160.901, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care").

Recognizing that government has a large influence on the practice of medicine, the AMA continuously works to reduce the burden of government and third-party regulation on medical practice and its intrusion into the patient-physician relationship and doctor-patient time (Policy

H-180.973, "The "Hassle Factor"). The AMA will continue these efforts, with additional focus on the prescription of medication (Policy H-100.971, "Preserving the Doctor-Patient Relationship"). Furthermore, the AMA endorses principles concerning the roles of federal and state governments in the patient-physician relationship:

> A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
> B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
> C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
> D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter (Policy H-270.959, "AMA Stance on the Interference of the Government in the Practice of Medicine").

It is AMA policy that the relationship between physicians and their patients should not be disrupted by direct communications from health plans to patients regarding individual clinical matters (Policy H-140.919, "Doctor/Patient/Health Plan Communications").

DISCUSSION

To appropriately respond to the resolution referred by the HOD, this report will focus on describing the factors that contribute to patient-physician relationships, including:

- Shared decision-making
- Online health/medical information
- Health literacy
- Trust
- Implicit bias
- Adequate time
- Physical clinic setting
- Communication
- External influences

Barriers to communication and an effective patient-physician relationship can be encountered at many points during the interactions between a patient and physician. Barriers can also manifest from inherent attitudes or outward behaviors, of the patient and/or physician. Finally, barriers that affect the quality of patient-physician interactions are often external environmental elements, such as technology or the availability of support staff.

Shared decision making

Sharing in the decision-making process can help patients feel their voice is heard and their physician cares what they think and feel about their condition and the options for treatment. Patients value having the opportunity to explain their illnesses, receive information, and be involved in their treatment plans.[1, 2] This requires deliberate attention and thoughtful consideration on the part of the physician. Barriers can arise if patients are simply presented with results and standard check-box choices without discussion. This approach can leave them feeling less than cared for. In addition, the use of decision support tools, while mostly beneficial when used appropriately, can get in the way of quality conversation in which patients and physicians decide together the best course of action.[3] A study of physicians with a "participatory decision-making style" showed this approach resulted in better health outcomes and more satisfied physicians. This research also found that physicians with a more participatory decision-making style were 30 percent less likely to have patients leave their care.

Online health/medical information

An important part of the patient-physician relationship is ensuring patients have the right amount of appropriate and accurate information about their health and medical conditions. In today's internet-driven and information-loaded environment, physicians are often not the initial source of information about medical conditions or potential treatments. Patients are increasingly arriving at a clinic visit after reading information on medical information websites, sometimes even with a specific diagnosis in mind. This can be either problematic or beneficial for the patient-physician relationship, depending on whether and how the patient discusses what they have learned with their physician.[4] For example, 80 percent of physicians report that access to online information has increased the likelihood that patients question their diagnosis or treatment plans.[5] Confirming this observation, a study of patient perspectives revealed that when patients valued information found on the internet above their physician's, that information led them to ignore their physician's expertise.[4, 6] On the other hand, if patients openly discuss their findings with their physician and the physician is receptive to that discussion, this open communication can benefit the patient-physician relationship.[4] Some patients believe that information seeking and discussion about that information with their physician enhances their relationship with their physician and supports their physician's advice.[4] While it can sometimes create barriers, online health and medical information accessed and used appropriately can benefit patients and physicians, and enhance their communication and overall relationship.

Health literacy

Although many patients are increasingly discussing self-searched health information with their physicians, and physicians are more often sharing information with patients throughout decision-making, it does not mean that patients always understand or can accurately interpret the information they are learning. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.[7] Low health literacy, primarily affecting older adults, minority populations, medically underserved people, and those with low socioeconomic status, can create barriers between the patient and their physician. Reasons for low health literacy include language limitations, limited education, use of medical vernacular by health care staff and clinicians, hearing impairment and cultural differences. These patients may have trouble communicating their complaints and health history to the physician or they may not understand the risks their behaviors pose on their health. They may not understand insurance and how to use their benefits, and they may have difficulty understanding medications and their effects.[7] For some, the increase in access to information has

improved understanding and knowledge of their health.[8] Although there is more online health care content than ever, and mobile health applications give patients more access and control over their health information, medical information websites or mobile applications are not always available to everyone. Patients with low health literacy are less likely to use computers and web applications (e.g., email, search engines, and online patient portals), limiting the benefits these sources of information have for certain populations.[9]

Trust

Trust between patients and their physicians is crucial. Patients may have a general distrust of the medical profession due to a bad experience. They may need time to build trust with their physician, or they may not feel their physician has their best interest in mind. Physicians, on the other hand, may lack trust in their patient if the patient ignores treatment or medication plans, cancels or doesn't show up for appointments, or neglects to provide complete information about health history. Shared decision making and open, non-judgmental dialogue about health and medical information as previously discussed, can help foster trust between patients and physicians. In addition, physicians and patients alike may harbor distrust as a result of implicit bias against the other party.[10]

Implicit bias

Implicit bias, on the part of the physician or the patient, negatively affects the patient-physician relationship for many reasons. For patients, biases about providers can have implications for access to care. For example, 29 percent of patients in one survey said they would avoid a certain provider based on personal characteristics such as race, gender, or age.[11] Getting in the way of a caring and respectful relationship are biased remarks made toward clinicians based on characteristics like weight, gender, or ethnicity. Fifty-nine percent of clinicians have experienced bias due to their physical appearances and 70 percent of Black and Asian clinicians report hearing biased remarks.[11] Some biases can exist based on accents or attire such as certain types of headwear. Physicians can also bring biases to their practice. Implicit attitudes about personal characteristics such as weight or race can affect the way they interact with and treat patients.[12, 13] Predisposed notions about patients based on these outward-facing characteristics can unfairly influence a physician's judgment about the individual's condition or the best course of treatment. This inhibits the quality of patient care and damages the patient's trust that the physician has their best interest in mind.

Adequate time

Sufficient time to focus on the patient during a clinic visit is important for both the patient and physician to develop and maintain a healthy and productive relationship. The patient needs time to ask questions and discuss their symptoms, concerns, and history. If they feel rushed by the physician, even if the physician does not intend to send that signal, the patient may feel unimportant and not cared for. The effective use of the patient visit by the physician gives the patient the sense they have been heard and they can comfortably express their concerns and feelings.[14] Feeling that they are the focus of the physician's attention and that they have been heard is more important to patients than the actual amount of time spent together.[1]

Likewise, physicians want to have sufficient time with their patients to gather important information, look their patients in the eyes, and really listen to their concerns. Research has shown that one of the primary sources of physician satisfaction is patient relationships and one of the primary sources of dissatisfaction is "time pressure."[15] Productivity requirements and pressure to keep appointments to short durations can put pressure on physicians to limit their visit lengths to

only a few minutes. In addition, documentation requirements force the physician to spend an inordinate amount of time focused on their electronic health record (EHR) rather than their patient.[16]

Recent data show that 33 percent of physicians in the U.S. spend 17 to 24 minutes with each patient. Twenty-nine percent spend 13 to 16 minutes, and just 11 percent spend 25 or more minutes with each patient.[17] Research shows that longer visits allow for more attention to several aspects of care, including increased patient participation, patient education, preventive care, and performance of immunizations. In addition, patients are more likely to feel they had inadequate time with their physician in visits scheduled to last five minutes compared with visits scheduled to last 10 and 15 minutes.[18, 19] In the U.S., visit rates above three to four per hour are associated with suboptimal visit content. Because patient satisfaction is increased by increased patient participation and activities to educate the patient, it is suggested that more than three to four visits per hour would be associated with decreased patient satisfaction.[20]

Despite the efforts to identify the "optimal" amount of time for patient visits, it remains an elusive goal, owing much to variability in patient visit lengths across specialties and countries.[20] In addition, because every patient is different and every patient-physician encounter is unique, it is difficult and not preferable, to designate a universal minimum time for patient visits. To improve the patient-physician relationship, the focus of physicians' energy should be on quality interactions and value-added tasks, rather than monitoring how many minutes they spend with the patient for billing purposes.

Physical clinic settings

The way in which a physician's office or patient room is designed and organized can create barriers to optimal communication with patients. Patient rooms in which a desk is placed so that the physician cannot look at the patient do not allow for valuable eye contact and hands-on interaction. A similar effect may occur if the physician places the computer screen between themself and the patient or looks at the computer screen while exchanging conversation. Research has shown that patient-physician communication can improve when the computer is placed alongside the patient and physician, rather than between.[21] Patients often perceive higher quality care and have less anxiety when visiting their physician when they find the practice environment attractive.[22, 23] Other design elements such as lighting can improve communication skills, mood, alertness, and performance for the entire care team.[23, 24]

Communication

Communication between physicians and their patients is critical to the success of their relationship. Communication can be verbal and non-verbal, and both types have an impact on the patient's outcomes and the effectiveness of the relationship. Verbal communication includes expression through words of empathy, assurance, explanations, humor, friendliness, summarization of the visit, and others. Non-verbal communication is seen in behaviors such as head nodding, direction of gaze, leaning, arm and leg crossing, and others. Clear and open communication between patients and physicians can enable better decisions about care[25] and better communication between patients and physicians is linked to both better patient outcomes[26, 27] and lower rates of physician burnout.[28] Factors that inhibit effective communication include all of the previously mentioned elements. In addition, general withholding of information by either the physician or patient diminishes the quality and appropriateness of care, reduces trust, and can put the patient at risk. Doctors tend to overestimate their abilities in communication. Tongue et al. reported that 75 percent of orthopedic surgeons surveyed believed they communicated satisfactorily with their patients, but only 21

percent of the patients reported satisfactory communication with their doctors.[29] Patient surveys have consistently shown that they want better communication with their doctors.[30]

External influences

Regulatory requirements and technological interference are also known to create barriers between patients and their physicians. The EHR and other technologies like mobile devices or health applications accessed through mobile devices can sometimes enhance, but often interfere with, the communication and quality of visits between patients and physicians. External factors can detract from the quality of care physicians feel they can provide; nearly 40 percent of physicians report patient care is adversely impacted to a great degree by external factors such as third-party authorizations, treatment protocols, and EHR design.[31]

Some of the external factors identified are significant inhibitors to the patient-physician relationship. EHRs, documentation requirements, and prior authorization each present specific challenges and outcomes that, from both the patient and physician perspective, are barriers to high-quality health care and communication. In addition, telemedicine has proven to be a valuable tool for delivering remote patient care, especially during the COVID-19 pandemic, but it presents its own challenges and barriers to the patient-physician relationship. A lack of access to technology or comfort with the use of technology can also hinder the patient-physician relationship and delay information exchange.

<u>Electronic Health Records</u>

In 2014 the AMA partnered with RAND to identify and describe obstacles to professional satisfaction and the ability to provide high-quality care. EHRs, when they interfere with face-to-face patient care, were found to detract from physician professional satisfaction.[32] The amount of time physicians spend doing administrative work includes more than half their day on completing tasks in the EHR and almost 90 minutes of EHR work at home after clinic hours.[33] Physicians also report that their EHRs have reduced or detracted from the quality of care, efficiency of practice, and interaction with patients.[31, 34]

While the EHR is a documented source of physician frustration and dissatisfaction, the design and function of the EHR system are only one part of the problems physician users experience while using their EHR. Decisions made by regulators, administrators, and policymakers influence the end use of EHRs, adding to the ways EHR use can interfere with patient care. For example, documentation requirements mandated by federal policy and payers result in physicians spending much of the patient visit looking at their computer screen instead of the patient. The quality of the implementation and training can make a difference in the effective use of the EHR during patient interactions. If users are not trained effectively, or the rollout of upgrades impedes daily work, efficient use of the EHR is undermined. Poor or no interoperability with other patient information systems can detract from the physician's access to current and relevant patient data.[35] All of these factors have the potential to contribute to unsatisfactory patient-physician communication.

Despite this, evidence shows the use of an EHR has no impact on the patient's satisfaction or perception of patient-physician communication, suggesting that EHRs may be more of an issue for physicians than patients.[36] Similarly, the RAND research showed EHRs facilitated enhanced communication with patients, contributing to improved satisfaction for some physicians. This was particularly true for communication outside the patient room. Fifty-four percent of physicians surveyed indicated using an EHR enhances patient-doctor communication that is not face-to-face. An excerpt from the report describes this experience:

> I think, if used correctly, [the EHR] definitely improves communication and helps in terms of patient care overall, with tracking what's going on with the patient. I think it's helped with patient-to-physician communication.

Documentation requirements

Increasing documentation requirements from Medicare and commercial payers have also added to physicians' administrative workload. A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive.[37] Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting, and increased demand for data. Much of the U.S. medical coding system is time-based,[38, 39] which has led to overemphasis on the amount of time spent with each patient and excessive focus on "checking the boxes" to ensure documentation requirements are met. The Centers for Medicare and Medicaid Services (CMS) recently enacted changes to the documentation requirements for evaluation and management (E/M) services developed by the AMA's CPT Editorial Panel. These changes will allow physicians to bill based on case complexity with less emphasis on the number of minutes spent. Physicians will only be required to enter medically necessary information, enabling them to spend more time connecting with their patient to collect high-value, relevant information instead of redundant information. Further discussion on the Medicare E/M coding changes and their anticipated benefits to the patient-physician relationship is presented in another section of this report.

To reduce the burden of documentation during patient visits, many physicians employ the use of documentation assistance tools or staff, such as speech recognition technology or medical scribes. It has been found that access to documentation support, such as that of a medical scribe, can increase the amount of direct face time with patients during a visit.[16] Medical scribes work in a variety of practice settings, including hospitals, emergency departments, physician practices, long-term care facilities, ambulatory care centers, and others. In a 2015 retrospective comparative study, physicians with medical scribes saw 9.6 percent more patients per hour than physicians without a medical scribe.[40] Physicians who use medical scribes say they "feel liberated from the constant note-taking that modern [EHRs] demand" and they can "think medically instead of clerically."[41]

When face-to-face time with the patient increases, physicians can listen and respond more thoroughly without the distraction of entering data into the EHR, giving patients a better experience. Physicians are in turn able to provide the level of care they find the most satisfying.[16] There is evidence the use of speech recognition technology and medical scribes improves physician satisfaction, including clinic, face time with patients, time spent charting, and accuracy and quality of their charts.[42] Patients also experience increased satisfaction with their physician visits when a scribe is present to document for the physician. In one study of patients surveyed about their physician's use of documentation assistance, 85 percent felt that having a scribe type notes for the doctor improved the overall quality of their visit. Seventy-four percent also said that they would like their other doctors to have scribes to type the exam notes.[43]

The evidence available suggests that documentation assistance, whether through the use of speech recognition technology or a medical scribe, can improve the communication and quality of visit between patients and their physicians. Board of Trustees Report 20-A-17, "Study of Minimum Competencies and Scope of Medical Scribe Utilization," provides additional information about the use of medical scribes in the practice of medicine.

Prior authorization

It has been well-documented, by the AMA and others, that prior authorizations required by payers are another source of dissatisfaction and burden for physicians.[44, 45] In addition to being a source of burden, a 2019 AMA survey showed 90 percent of physicians reported prior authorization has a negative impact on patient clinical outcomes. Seventy-four percent said prior authorization can lead to treatment abandonment, and 24 percent said prior authorization led to a serious adverse event for a patient in their care.[45] The financial toll, emotional distress, and psychological effects on patients of treatment delays and confusing prior authorization procedures can be substantial.[46] These effects could also lead to patients avoiding treatment or seeking care in the future, ultimately undermining the patient-physician relationship and the physician's ability to provide the best care for their patients. Reducing the prior authorization burden would return some of the physician's autonomy and help ensure the patient receives the appropriate care, helping to strengthen the relationship between patient and physician.

Telehealth

Telehealth has been a tool for delivering remote patient care for many years but was not widely adopted. The onset of the COVID-19 pandemic in early 2020 drastically expanded the use of telemedicine services for patient care delivery.[47] Connectivity issues or general technological challenges may create barriers for effective telemedicine visits, and access to the technology may not be available for all patients, leading to the potential risk of jeopardizing the patient-physician relationship. Telehealth has proven its value to the practice of medicine, and there are many benefits to both the patient and physician,[48] yet some concerns about telehealth contributing to the erosion of the patient-physician relationship remain. Although AMA policy supports establishing patient-physician relationships via telehealth when clinically appropriate, it is still recommended that the establishment of a new patient-physician relationship take place during an in-person visit.[49] This in-person connection, a bond-forming element based on human awareness of personal space and the healing effects of human touch and face-to-face interactions, is integral to successful patient-physician relationships.[50]

AMA advocacy, research, and resources

Our AMA has historically advocated on physicians' behalf for changes in policy and practice that would improve and enhance the patient-physician relationship. AMA's ongoing advocacy aims to reduce documentation burden, reform prior authorization requirements, increase transparency, and improve EHR technology so physicians can spend more time with their patients.

In addition to its tireless advocacy efforts, our AMA has worked on many levels to develop resources and education for physicians to help enhance their communication and relationship with their patients. In addition, the AMA has dedicated significant resources to researching the factors that detract from physicians' ability to provide high-quality patient care, including but not limited to the studies previously referenced in this report. AMA supports and carries out research efforts aimed at understanding and identifying solutions to the issues that create barriers between physicians and their patients. The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physician's work day.[16] The AMA published a report on bullying in the practice of medicine and the effects it can have on physician well-being and their ability to provide high-quality patient care.[51] The AMA has also published research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development.[33, 52] The AMA's research includes a time-motion study to determine how much and in what ways physicians spend time completing tasks in their EHRs. The AMA has also published

eight EHR usability priorities, which outline and support the need for better usability, interoperability, and access to data for both physicians and patients.[53] If followed, these priorities will enable the development of higher-functioning, more efficient EHRs, contributing to a reduction in the burden that EHR use places on patient care.

In 2019 the AMA established the Center for Health Equity to embed health equity into the processes, practices, innovations, and performance of our AMA. This unit works to help the AMA address issues that contribute to health disparities and inequity, including bias, stereotyping, and prejudice, which can all inhibit a successful patient-physician relationship. By helping to reduce these implicit influences, AMA enhances its ongoing work to preserve the integrity of physicians' relationships with their patients.

Multiple collaborations are in place to help foster better EHR design and innovative health information technology (HIT) solutions to help make the EHR user experience better and more efficient. The AMA has established collaborations and partnerships with the organizations such as SMART Initiative, AmericanEHR Partners, Carequality, Sequoia Project and Medstar Health's National Center for Human Factors in Healthcare to help foster innovative HIT design interoperability and transparent testing solutions which will to help ensure EHRs are designed and implemented with physicians and patients in mind. The AMA Physician Innovation Network also connects physician experts with industry innovators to facilitate the integration of the clinical voice and the patient experience into HIT innovation. Finally, the AMA recently worked with various industry stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification framework which will help catalyze an industry-wide shift to higher-quality EHR systems that enable better, more efficient use.

The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state and specialty medical societies, national provider associations, and patient representatives to develop a set of Prior Authorization and Utilization Management Reform Principles.[54] These principles spurred conversations between health care professionals and insurers on the need for prior authorization reform, which culminated in the release of the Consensus Statement on Improving the Prior Authorization Process.[55] The consensus document reflects an agreement between national associations representing both providers and health plans on the need to reform prior authorization programs in multiple ways, including reducing the overall volume of prior authorizations and advancing automation to improve transparency and efficiency. The AMA, in addition to providing an evidence base demonstrating the need for prior authorization reform, offers multiple resources to help physicians understand prior authorization laws and improve processes within their practices.

The AMA and CMS in 2019 worked together to achieve the first overhaul of E/M office visit documentation and coding in more than 25 years. Specifically, Medicare began to allow physicians to document review and verification of history entered into the medical record in lieu of re-entering the same information. For established patients, history and examination already contained in the medical record no longer needs to be re-entered and physicians can document only what has changed and relevant items that have not changed since the patient's last visit. The changes implemented are a significant step in reducing administrative burdens that get in the way of patient care and will allow physicians to spend more time with their patients, one of the key elements to a meaningful patient-physician relationship. Considering the variation in patients, case complexity, and specialty-specific needs, the AMA is not in favor of imposing a universal minimum time for patient visits and supports these changes that enable physicians more flexibility determining the appropriate amount of time to dedicate to their patients. The AMA is collaborating with the University of California San Francisco to investigate changes in documentation and coding time,

perceived burden and physician burnout throughout the phases of the E/M coding changes. The outcomes of this research will help institutional leaders and physicians identify additional opportunities to reduce physician administrative burden and increase time spent with patients. This research will also prioritize and inform advocacy efforts with federal (e.g., CMS) and state regulators, commercial plans and EHR vendors to further address issues such as coding, documentation. and burden reduction on behalf of physicians, their practices and patients.

The AMA during the COVID-19 pandemic has advocated for the expansion of and reimbursement for telehealth so that patients can experience continuity of care and so physicians are adequately compensated for their time providing remote patient care. The AMA's Digital Health Implementation Playbook series offers comprehensive step-by-step guides to implementing telehealth in practice.[56] Each Playbook offers key steps, best practices, and resources to support implementation. The AMA continues to publish new guidelines and resources, as well information about the latest updates on telehealth expansion amid COVID-19.

The AMA offers and continues to develop education modules that teach strategies and tactics to help physicians save time on clerical and basic clinical tasks so that they have more time for relationship-building and medical decision making with patients. Many of AMA's STEPS Forward™ modules address some aspect of organizational culture or practice efficiency to help physicians optimize their patient relationships, including several that aim to help practices save time, communicate more effectively, and improve patient and provider satisfaction.

The AMA's ongoing work to reduce physician burnout strives to remove the obstacles and burdens that interfere with patient care or hinder communication with patients. This work includes the AMA Practice Transformation Initiative (PTI), which supports researchers in building evidence on effective interventions to reduce burnout and increase physician satisfaction within their health systems. Interventions implemented through the PTI include measures to enhance the roles of non-provider care team members to reduce administrative burden for physicians, and to gain efficiencies in physician time. Other interventions aim to help clinicians maximize their practice efficiency, promote self-care, and address sources of burnout and stressful workplace situations. The AMA also offers institutional assessments to help organizations measure burnout among their physician staff, implement improvements, and develop evidence-based support systems within their practices, reducing burnout and improving physicians' ability to provide high-quality patient care. In addition, the AMA offers a guideline, "Collaborative communication strategies: Partner with patients," to help clinicians communicate clearly and effectively with patients, particularly about treatment adherence which is one of the key elements of a successful patient-physician relationship.[57]

CONCLUSION

Many factors contribute to the dynamics of a relationship between a patient and physician, including shared decision-making, online health and medical information, health literacy, trust, implicit bias, physical settings, communication, and external influences. These factors have been studied and written about at length. The evidence shows that patients and physicians both have better experiences when they feel they have adequate time for talking and making decisions about treatment together. Physicians have better experiences when they have assistance with documentation so they can spend more of their visit face-to-face with their patients rather than looking at the computer. Physicians are more satisfied with their patient relationships when patients trust them. Patients are more satisfied with their clinic visits and their physicians when they feel they have been listened to and allowed to talk about their concerns. Improving communication and

preventing implicit biases from influencing care decisions are ways both physicians and patients can ensure their relationships with one another are healthy, trusting, and productive.

Considering the volume and range of published literature about the barriers to patient-physician relationships identified in Resolution 703-A-19 and discussed in this report, it is not recommended that additional formal research be undertaken by the AMA. The AMA will continue to dedicate significant resources to helping physicians overcome these barriers to enhance and preserve their relationships with their patients.

RECOMMENDATION

The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be filed.

Fiscal note: None

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-JUN-2021

Subject: Amending the AMA's Medical Staff Rights and Responsibilities (Resolution 710-NOV-20)

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee G

At the November 2020 Special Meeting, the House of Delegates (HOD) referred Resolution 710, "A Resolution to Amend the AMA's Physician and Medical Staff Bill of Rights." Resolution 710 was sponsored by the Medical Society of Virginia and instructed the AMA to amend Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," to add new text to the preamble as shown below:

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

<u>The AMA recognizes the responsibility to provide for the delivery of high quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body, and relies on accountability and inter-dependence with government and public health agencies that regulate and administer to these organizations.</u>

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The AMA supports the right to advocate without fear of retaliation by the health care organization's administrative or governing body including the right to refuse work in unsafe situations without retaliation.

The AMA believes physicians should be provided with the resources necessary to continuously improve patient care and outcomes and further be permitted to advocate for planning and delivery of such resources not only with the health agency but with supervising and regulating government agencies.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:
…

Testimony overwhelmingly supported referral of Resolution 710, noting the complexity of issues raised by the proposed changes. In particular, testimony reflected that while the suggested additions were particularly timely during the COVID-19 pandemic, the enumeration and description of medical staff and physician rights and responsibilities should be considered carefully with an eye toward how these immediate needs might fit into a description of broader, longer-term concerns.

DISCUSSION

Resolution 710 ultimately sought to protect individual physicians and medical staffs collectively from retaliation or retribution when speaking out, either publicly or privately, about physician or patient care concerns. This issue has been particularly applicable during the COVID-19 pandemic as physicians across the country sought to address the lack of access to adequate personal protective equipment. Protecting physicians in and outside of their places of work and empowering them to advocate on behalf of their patients are long-standing tenets of AMA practice and policy, so their inclusion in an enumeration of medical staff and physician rights and responsibilities should be supported.

Resolution 710 affirms the right of physicians to advocate, both inside and outside of their organizations, for what they and their patients need. Individual physician and medical staff advocacy directed at an organization's administration and governing body is encouraged and should be conducted freely, without fear of retaliation or retribution. Advocacy efforts oriented toward external decisionmakers should be informed by medical staff input and even be guided by it when appropriate. While conscientious physicians will take care to ensure internal and external advocacy efforts are conducted in a way that does not disadvantage care delivery or unnecessarily interfere with their organizations' operations, physicians advocating either independently or collectively always should be protected from undue adverse consequences.

Accordingly, we support the content additions proposed by Resolution 710. But we note the importance of properly integrating these ideas into the existing policy. Much of the proposed verbiage is already included in the "rights and responsibilities" portion of the existing policy, with Resolution 710 proposing that it be repeated in the preamble. In order to preserve the expository role of the preamble, which is intended to address the theoretical underpinnings of medical staff and physician rights and responsibilities and explain why enumerating them is necessary, we instead recommend that the ideas set forth by Resolution 710 be incorporated into the rights and responsibilities articles themselves.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution710-NOV-20 and that the remainder of the report be filed:

1. That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition and deletion:

   Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

   Preamble

   The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

   The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

   Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

   From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

   I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
   b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
   c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
   d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:
a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care ~~or,~~ medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-JUN-21

Subject: Council on Medical Service's Sunset Review of 2011 House Policies

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

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

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

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

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

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

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

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RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-125.992	Opposition to Prescription Prior Approval	Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11)	Retain. Still relevant.
D-165.985	Evolving Internet-Based Health Insurance Marts	Our AMA will continue to monitor the evolution of the Internet-based health benefits industry and report to the House of Delegates on important developments. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-165.839, which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

Policy #	Title	Text	Recommendation
			E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
D-385.960	Appropriate Payments for Vaccine Price Increases	Our AMA will work with national specialty societies to educate physicians to include language in their health insurer contracts to provide for regular updating of vaccine prices and payment levels, which should include	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		real-time adjustments in vaccine pricing. (Res. 807, I-11)	
D-390.958	The Impact of National Physician Payment Reductions on the National Unemployment Rate	Our AMA will expand its previous studies on the economic impact on the medical practice for the purpose of developing data on the negative economic impact on physician practice employees and communities of incremental SGR cuts and will include in future communications with the US Congress, other stakeholders, and the American people, data-driven information on the national economic impact, including the impact from potential loss of employment of medical practice employees and others, due to payment decreases for physician practices. (Res. 218, I-11)	Rescind. The SGR was repealed in 2015. Moreover, the AMA regularly conducts economic analyses that inform AMA advocacy on behalf of physician practices, including a COVID-19 Physician Practice Financial Impact Survey and Changes in Medicare Physician Spending During the COVID-19 Pandemic.
D-400.991	gCPT Modifiers	(1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers. (2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers. (3) Our AMA use the available information to engage in discussions with payers. (4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators. (Sub. Res. 808, I-01; Modified: CMS Rep. 7, A-11)	Rescind. Superseded by Policy D-70.971 which states: (1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers. (2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate. (3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans. (4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers. (5) Our AMA will include in its model managed care contract, provisions that will require

Policy #	Title	Text	Recommendation
			managed care plans to adhere to CPT rules concerning modifiers. (6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers. (7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions. (8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.
D-400.994	Conscious Shedation	Our AMA will support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) as they review the coding and valuation issues related to procedures that are performed using moderate sedation/analgesia (i.e., "conscious sedation"). (Res. 107, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Directive accomplished. New CPT codes for moderate sedation were implemented and RUC recommendations were adopted by CMS in 2017.
D-435.996	Malpractice Insurance Rate Increases and Physician Reimbursement	Our AMA will: (1) call upon the CMS to use current data in calculating the malpractice insurance portion of the Resource-Based Relative Value Scale and that this calculation take into account inter-specialty and geographic variances; and (2) study the calculated malpractice insurance portion of the RBRVS to determine the effect increasing malpractice insurance costs have on physician reimbursement. (Res. 109, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
D-70.983	Inappropriate Bundling of Medical Services by Third Party Payers	Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate	Retain. Still relevant.

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		bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician; (5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and. (6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue. (CMS Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-100.964	Drug Issues in Health System Reform	The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package. (2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited. (3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices. (4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the	Retain-in-part. The following subsections should be rescinded for the reasons provided below. Policy H-100.964 should otherwise be retained as still relevant. (4) Policies H-120.974 and H-125.992 have since sunsetted. (8) Superseded by Policy H-35.999. (9) Policies H-115.995 and H-115.997 have since sunsetted. (10) Superseded by Policy H-125.989. (15) Superseded by Policy H-120.988. (17) Policy H-120.983 has since sunsetted.

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		substitution of FDA B-rated generic drug products. (5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991. (6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978. (7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs. (7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information. (8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance. (9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs. (10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive "formulary" drug because economic	

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		incentives can interfere with pharmacist professional judgment. (11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling. (12) supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities. (13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities. (14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses. (15) encourages the use of three compendia (AMA's DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs. (17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS	

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		Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11)	
H-130.945	Overcrowding and Hospital EMS Diversion	It is the policy of the AMA: (1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds; (2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department; (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups; (4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities; (5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and (6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions. Citation: (CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02;	Retain. Still relevant.

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		Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11	
H-155.974	Excessive Regulatory Costs	Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals, (2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated; (3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and (4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79; Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-165.862	Evolving Internet-Based Health Insurance Marts	Our AMA endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-165.839, which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange

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			and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices. 2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion

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			of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.
H-180.948	Opposition to Incentives for Care in Non-Physician Clinics	Our AMA will communicate with large insurance companies that providing incentives to patients toward non-physician clinics outside the primary care physician relationship can lead to decisions made on limited information, duplication of testing and procedures, ultimately higher health care costs and a reduction in the quality of health care for the patients of America. (Res. 708, A-11)	Retain. Still relevant.
H-185.943	Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes	Our AMA affirms its support for elimination of health care disparities caused by differential treatment based on insurance status of Americans. (Res. 119, A-11)	Retain. Still relevant.
H-185.985	Internal Guidelines Used by Third Party Payers to Determine Coverage	Our AMA calls upon all third party payers and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (Res. 126, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-185.984, which supports 24-hour-a-day access to patient coverage and benefits information.
H-200.995	Federally Funded Clinic Programs	Our AMA supports the following policy statements regarding federally funded clinics: (1) Physician services should be available in underserved areas and should be provided in a manner which ensures continuity of patient care, integration with the existing health system, and retention of the health providers. (2) Physicians should be sensitive and responsive to indicators of need for additional health personnel or accessibility of health care. Through their component medical society, physicians should seek involvement in the designation process for Health Manpower Shortage Areas and	Retain. Still relevant.

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		Medically Underserved Areas. The medical community and local residents are in an excellent position to ascertain the need for additional health providers in the community, and to support appropriate decisions in that regard. (3) Where need is clearly identified, through a federal designation process or other means, the local medical community should explore alternatives for responding appropriately to meet the need. (4) Where physicians have responded appropriately to needs identified through the designation process, the component medical society should work with the local planning groups to remove the area's designation, so that federal resources are not called on to duplicate services. (5) Where identified needs cannot be met by the local medical community, and all local public and private financial assistance options are determined to be inadequate, federal assistance should be sought. In such cases, the local medical community should assume the responsibility of working with the agency applying for federal funds to facilitate the placement of health personnel with long range service potential. (6) Where inappropriate designations were made leading to capacity which exceeds the need, the patient volume is likely to be low, and the unit costs excessive. In such situations, constructive consultation between the local medical community and the federally funded clinic program should explore options for a resolution of the problem. (Res. 125, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-215.964	Patient Identification Wrist Bands	Our AMA (1) supports the concept of uniform patient identification wrist bands at all hospitals and other health care facilities where wrist bands are used; (2) encourages the adoption of uniquely colored patient identification wrist bands for specific patient information, such as, patient's name, allergies and those with identified greater fall risk; and (3) will actively pursue national standardization of	Retain. Still relevant.

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		color-coded wristbands in hospital settings. (Res. 727, A-07; Appended: Res. 720, A-11)	
H-215.971	Standardization of Emergency Paging Nomenclature	Our AMA urges the development of standardized emergency paging nomenclature for hospitals. (Sub. Res. 805, A-00; Reaffirmation A-09; Reaffirmation A-11)	Retain. Still relevant.
H-215.984	Duplicate Bureaucratic Regulations	Our AMA encourages the identification of duplicate regulatory activities and inspection in hospitals and nursing homes so that these matters may be brought to the attention of legislators, governors and regulatory agencies. It is AMA policy that such information be made available nationally via the AMA and the AHA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations. (Res. 53, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	Retain. Still relevant.
H-215.994	Subrogation by Hospitals	Our AMA urges hospitals to insist that contracts for hospital professional liability insurance require that the carrier obtain the consent of the policy holder prior to initiating legal action against a physician in the name of the hospital. (Res. 2, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-215.996	Compensation for Service on Government Mandated and Funded Hospital Committees	Our AMA believes that federal or third party funds provided for reimbursement of physicians serving on mandated hospital review committees should not be diverted by the hospital for other purposes. (CMS Rep. H, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.930	Regulatory Standards Should be Evidence-Based	Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be	Retain. Still relevant.

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		appended to the documentation for every clinical standard imposed on health care institutions and providers. (Res. 727, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-220.950	Medical Staff Involvement in Hospital Compliance With Accrediting Organization Standards Plans of Action to Correct Deficiencies	Our AMA: (1) adopts the policy that a hospital medical staff must be appropriately involved in a surveyed organization's development of a plan of action to correct a deficiency and that such involvement be consistent with existing medical staff bylaws, rules and regulations; (2) encourages hospital medical staffs to amend their bylaws, if necessary, to establish processes to ensure appropriate medical staff input into the development of a plan of action to correct a deficiency; and (3) urges accrediting organizations to work to ensure that these principles are part of their accreditation standards. (Res. 810, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-220.953	Quality Improvement Requirements for Leadership Structures of Health Care Organizations	Our AMA supports the following concepts for incorporation in The Joint Commission's accreditation programs for health care organizations: (1) establish accreditation programs with greater emphasis on the assessment of the effect that actions and decisions of the administrative and governing bodies of health care organizations have on the quality of patient care; (2) establish the requirement that management efforts must be made in concert with those of physicians, nurses and other health care professionals pursuant to the needs of the patients served by these professionals and the prevailing standards of practice; (3) establish the requirement of assessing major processes in the health care organization with the goal of continuous improvement rather than intensely focusing on individual persons or services; (4) establish the requirement that risk management processes be established that will emphasize prevention of problems rather than policies that call for taking action only after a problem has arisen; (5) establish accountability of the management and governance elements	Retain. Still relevant.

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		of a health care organization to its professional staff of physicians and nurses; and (6) require that the bylaws of the governing body provide a process through which the medical staff could appeal any decision made by the administration and/or the governing body which has an adverse effect on the quality of care rendered to patients, require that medical staff bylaws provide a process by which the need for such an appeal is identified, and provide a process for making the appeal. (Res. 822, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	
H-220.995	Hospital Guidelines Impact Statement	Our AMA recommends that when guidelines, rules and specific recommendations to hospitals and other medical facilities are originated by accreditation, certification or regulatory agencies, they include a proof of impact statement to include (1) actual or estimated costs of implementation (as a total cost or cost per bed). Included in the costs should be estimates of volunteer medical staff time required to implement the policy; (2) a brief statement of the expected benefit, goal or improvement in health care or reduction in health care costs; (3) a brief outline of the data tending to prove that the guidelines and rules will actually and significantly improve patient care, not have an adverse impact, and will accomplish the intended goal stated in the benefit statement; and (4) cost estimates of implementation and ongoing compliance, for small, medium, and large hospitals, and/or other health care facilities. (Res. 37, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed in lieu of Res. 816, I-93; Amended: Sub. Res. 805, I-01; Modified: CMS Rep. 7, A-11)	Retain. Still relevant.
H-225.952	The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs	Our AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent	Retain. Still relevant.

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		exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights. (BOT Rep. 2, I-11)	
H-225.972	AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs	It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible. (Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-235.974	Autonomy of the Hospital Medical Staff	Our AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; and (3) understands that there are physicians who are not members of the medical staff but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Res. 832, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-240.997	Patient Signatures for Medicare Payment	Our AMA endorses a proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by	Retain. Still relevant.

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		CMS for Medicare payment for inpatient hospital care. (Res. 15, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-25.989	Long-Term Care Prescribing of Atypical Antipsychotic Medications	Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare." (Res. 819, I-11)	Retain. Still relevant.
H-285.920	Criteria for Level of Care Status	(1) Our AMA support the development and use of level of care guidelines that meet the following criteria: (a) Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions; (b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances; (c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment; (d) Level of care guidelines should be developed under the direction of actively practicing physicians; (e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service;	Retain. Still relevant.

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		(f) Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus; (g) Level of care guidelines should be reviewed and updated; and (h) Level of care guidelines should allow for a timely appeal process. (2) It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. (CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-285.921	Managed Behavioral Health Organizations (MBHOs)	It is the policy of our AMA that, when requested, Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient's permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient's treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient's health care needs in optimal fashion. (Res. 702, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-290.981	Out-of-State Medicaid Patients	The AMA encourages the CMS to propose regulations that prohibit state Medicaid programs from requiring physicians and other providers to be credentialed in the patient's state of residency, as long as the physician or provider is credentialed where the care is rendered. (Res. 136, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmation A-11)	Retain. Still relevant.
H-330.891	Payment and Coverage for Voluntary Discussions of End-of-Life Issues	Our AMA encourages the Centers for Medicare & Medicaid Services to designate voluntary discussions of end-of-life issues as covered services as part of the 2012 Medicare Physician Fee Schedule rule. (Res. 225, A-11)	Rescind. Accomplished in 2019 when the Centers for Medicare & Medicaid Services began paying for advanced care planning using CPT codes 99497 and 99498.
H-330.954	Mandatory Transmission of	Our AMA opposes the policy of local Medicare carriers of mandating that physicians choose between electronic	Retain. Still relevant.

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	Electronic Claims	remittance advice or standard paper remittance report until all secondary insurers accept the electronic remittance advice explanation of benefits in its present format. (Res. 815, A-93; Appended: Res. 107, I-00; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)	
H-340.997	Medicare Preauthorization Review	Our AMA opposes the mandating of blanket hospital preadmission review for all patients or for specific categories of patients by government or hospital edict, and supports the prerogative of physician-directed peer review organizations to implement focused preadmission review on a voluntary basis. (CMS Rep. G, A-84; Reaffirmed by CLRPD Rep. 3-I-94; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-345.976	Medicaid Coverage of Adults in Psychiatric Hospitals	1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders. 2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes. 3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. (CMS Rep. 3, A-11)	Retain. Still relevant.
H-35.992	Reimbursement for Allied Health Personnel	Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)	Retain. Still relevant.
H-380.995	Insurance Carrier Terminology	Our AMA urges individual physicians to consider including in their patient information materials an explanation as to why the amount billed may in some cases be more than the insurance benefit paid. (CMS Rep. F, I-81; CLRPD Rep. F, I-91; Reaffirmed:	Rescind. Superseded by Policy H-390.865, which calls for a universal EOB to be issued to both the patient and the physician that includes an explanation of billed, covered and patient responsibility amounts.

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		Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-383.994	Managed Care Plans and the Right to Set Fees	Our AMA opposes any government or hospital requirement that a hospital-based physician must accept the terms of any managed care plan accepted by the hospital. (Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.916	Reimbursement for Office-Based Surgery Facility Fees	Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities. (Res. 716, A-11)	Retain. Still relevant.
H-385.917	Interpreter Services and Payment Responsibilities	Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. (CMS Rep. 5, A-11)	Retain. Still relevant.
H-385.925	Selective Revenue Taxation of Physicians and Other Health Care Providers	Our AMA: (1) strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; (2) will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate; (3) strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and (4) believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs. (Sub. Res. 258, A-92; Reaffirmed: Res. 134, A-93; Res. 207, I-93; Reaffirmation A-99; Reaffirmation A-00; Appended Res. 132, A-01; Reaffirmation A-05; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 6, I-11)	Retain. Still relevant.
H-385.932	Contact Capitation Contracts	Our AMA strongly encourages all physicians contemplating entering into contact capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under contact capitation arrangements and potentially uncontrollable market forces that may impact upon ones	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		ability to provide quality patient care. (CMS Rep. 1, A-01; Modified: CMS Rep. 7, A-11)	
H-385.940	CPT Codes for Evening and Night Services	Our AMA will continue its efforts to advocate for the fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services and unusual travel. (Sub. Res. 821, A-98; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.967	Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims	It is the policy of our AMA to investigate and document reports of problems with delays in payments by third party payers, including the federal government, and to seek legislation or regulations that assure prompt payment by all third party payers. (Res. 113, I-91; Reaffirmed: Res. 138, A-98; Reaffirmation I-01; Reaffirmation I-04; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: Res. 216, A-11)	Retain. Still relevant.
H-385.968	Physician Fee Determination by Contractual Arrangements Between Third Party Payers and Hospital	Our AMA condemns the practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (Sub. Res. 248, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.970	Payment of Physicians' Services for Patients in Observational or Short Stay Units	Our AMA supports seeking reimbursement from all third party payers for physicians' services to patients who are appropriately managed in short stay units. (Res. 182, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-385.995	Manipulative Casting of Congenital Deformities of the Extremities	Our AMA encourages all third party payers to classify manipulative casting of congenital deformities of the extremities as a surgical procedure, whether performed in the office or hospital. (CMS Rep. L, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.889	Medicare Reimbursement of Telephone Consultations	It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		payment for telephone calls not covered by payments for other services; (2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services; (3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes; (4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and (5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence. (CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmation A-07; Reaffirmed in lieu of Res. 824, I-11)	
H-390.895	Medicare Patient Surveys	It is the policy of the AMA to negotiate with CMS to rescind rules and regulations that inordinately withhold payment to physicians for services rendered to Medicare beneficiaries until the beneficiary completes a survey or questionnaire. (Res. 102, I-91; Reaffirmation A-01; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.901	Medicare Outpatient Service Charge Limit	Our AMA vigorously opposes the Medicare Part B Policy of Outpatient Physician Charge Limit. (Res. 70, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-390.906	Medicare Notification of Payment	Our AMA requests CMS to direct Medicare Part B carriers to furnish all physicians with an Explanation of Medicare Benefits on all claims whether assigned or nonassigned. (Res. 62, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-405.980	Caller Identification	Our AMA, based on the concerns of protecting physicians' privacy,	Rescind. No longer relevant.

Policy #	Title	Text	Recommendation
		supports efforts to allow individuals to block caller identification at no cost to the caller. (Sub. Res. 225, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	
H-45.986	Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft	Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as "non-scheduled." (Sub. Res. 144, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. Superseded by Policy H-45.997, which supports legislation to provide immunity to physicians providing care during an in-flight medical emergency.
H-450.961	Health Plan "Report Cards"	The AMA: (1) supports the development and appropriate use of health plan performance standards; (2) The AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures; (3) The AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results; (4) The AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures; (5) The AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles: (a) Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.	Retain-in-part. The text of the policy remains relevant and should be retained. To better reflect the content of the policy, the title should be amended by addition and deletion as follows: ~~Health Plan "Report Cards"~~ Health Plan Performance Measures

Policy #	Title	Text	Recommendation
		(b) The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential. (c) Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures. (d) Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services. (e) The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged. (f) Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed. (g) Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status. (h) Health plan performance data that are self-reported by health plans shall be verified through external audits. (i) The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public. (j) Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release. (k) Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed. (l) The validity and reliability of health plan performance measures shall be evaluated regularly. (CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmation A-11)	
H-450.975	Definition of Quality	Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		to which care services influence the probability of optimal patient outcomes. (CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
H-450.976	Corrective Action and Exclusive Contracts	It is the policy of the AMA that exclusive contracts should never be used as a mechanism to solve quality assurance problems in lieu of appropriate peer review processes. (Res. 3, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.984	Access to Physician Services in Rural Health Clinics	Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. (Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-465.997	Access to and Quality of Rural Health Care	(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-87; Modified: Sunset Report, I-97;	Retain. Still relevant.

Policy #	Title	Text	Recommendation
		Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)	
H-478.989	Biometric Technologies Used to Enhance Security	Our AMA encourages the use of biometric technologies where feasible, such as, but not limited to, fingerprint and palm scanners in hospitals and clinics (1) for patient identification to improve patient safety while reducing health insurance fraud and (2) for providers to streamline and secure user authentication processes and better protect patient privacy. (Res. 816, I-11)	Retain. Still relevant
H-478.996	Medical Care Online	It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain. Still relevant.
H-70.917	Ensuring CPT Usage of the Term Physician is Consistent with AMA Policy	1. Our AMA will ensure that CPT employ the term "physician" consistent with our AMA's policy in all internal and external communications, publications and products. 2. As a condition for licensure of CPT intellectual property by outside entities, references to the term "physicians" within CPT must remain consistent with our AMA's policy, and the AMA will take appropriate enforcement action against violators. 3. Our AMA will ensure that the CPT code set continues to be applicable and relevant to physicians and qualified healthcare professionals who may report the professional services described therein. (Res. 602, I-11)	Retain. Still relevant.
H-70.974	CPT Coding System	1. The AMA supports the use of CPT by all third-party payers and urges them to implement yearly changes to CPT on a timely basis. 2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance. (Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11)	Retain. Still relevant.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-JUN-21

Subject: Universal Basic Income Pilot Studies (Resolution 236-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates referred Resolution 236, which was sponsored by the Medical Student Section and asks that the American Medical Association (AMA) support federal, state, local, and/or private Universal Basic Income pilot studies in the United States that intend to measure health outcomes and access to care for participants.

This report provides background on Universal Basic Income (UBI) proposals, outlines potential funding mechanisms for a UBI program, provides numerous examples of past and current UBI pilot programs and, where available, any resulting outcomes, details relevant AMA policy, and provides recommendations consistent with ongoing AMA advocacy efforts.

BACKGROUND

Some economists and policymakers argue that, although there was strong 3.4 percent growth in gross domestic product (GDP) in 2019 and low rates of unemployment, those numbers conceal the fact that many families are struggling financially. Wage growth remains stagnant, and nearly 1 in 10 employed adults work as contractors with limited job security and therefore employment benefits such as health insurance and long-term financial security. Moreover, the novel coronavirus (COVID-19) pandemic is severely exacerbating these health and economic issues. There have been more than 48 million jobless claims in the US since March. At the time this report was written, about 31.8 million people are receiving unemployment benefits, which equates to about 1 in 5 individuals in the workforce.[1] Simultaneously, the US continues to set record numbers of COVID-19 cases with cases trending upward in 39 states.[2] In light of the pandemic, the International Monetary Fund projects that growth in the US will fall 8 percent in 2020 and overall worldwide output will fall 4.9 percent.[3]

UBI is one method that is being suggested as having the potential to address current income inequality and to mitigate the loss of jobs caused by technological advances and COVID-19. UBI is an economic support mechanism typically intended to reach all or a large portion of the population.[4] It is particularly noteworthy and contrasted with current US welfare programs in that receipt of UBI comes with no or minimal conditions. According to the International Monetary Fund, in formulating a UBI plan, policymakers generally grapple with three primary considerations: who is eligible, the generosity of the UBI transfers, and the fiscal cost.[5] Some UBI proposals are universal while others are targeted to lower-income populations. Additionally, policymakers must weigh the incentives and disincentives of the generosity of transfers. For example, they must determine how UBI will affect decisions to enter the workforce and the number of hours worked. Finally, and perhaps most importantly, policymakers must determine the fiscal cost of implementing UBI to governments in an environment of limited financial resources.[6]

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Proponents of UBI claim that it would help break the poverty cycle and dependency on welfare programs. They claim UBI will give the disadvantaged the time and money to seek higher education and needed job training.[7] Others claim that UBI would disincentivize work. However, decreased working hours has not been established in UBI trials to date.[8]

Advocates mention that UBI could replace the current complicated safety net. The US has a patchwork benefits system with programs including but not limited to:

- Supplemental Nutrition Assistance Program: Provides nutrition benefits to supplement the food budget of families in need so they can purchase healthy food.
- Temporary Assistance for Needy Families: A time-limited program that assists families with children when the parents or other responsible relatives cannot provide for the family's basic needs.
- Children's Health Insurance Program (CHIP): Provides health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP also covers pregnant women.
- Section 8: Housing choice voucher program assisting low-income families, the elderly, and the disabled, to afford safe and sanitary housing in the private market.
- Earned Income Tax Credit: A refundable tax credit to low- and moderate-income individuals, particularly those with children.
- Special Supplemental Nutrition Program for Women, Infants, and Children: Provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are at nutritional risk.
- Supplemental Security Income: Program providing cash benefits to meet the needs of elderly, blind, and disabled individuals who otherwise have challenges paying for food and shelter.

Every year, the US spends nearly $1 trillion across dozens of state and federal programs amounting to significant administrative oversight across multiple agencies.[9] However, some critics of the programs state that the complex network of resources is a consequence of having different programs intentionally target different populations with varying needs and that the purpose of each program is distinct.[10] Critics of UBI state that it amounts to redistribution but does not necessarily advance mobility or represent an investment in human capital. Rather, they believe, society should focus its collective efforts on reforming current safety net programs to better meet their intended goals.[11]

FUNDING

Regardless of where one stands on UBI, how to pay for it is the primary challenge. Some estimates put the annual price for a US program in the trillions. Presumably, such a high cost would have to be funded through some type of taxation.

Some UBI advocates claim that such a high cost would be offset by savings as fewer people require welfare, food stamps, and other social programs. Moreover, advocates argue, UBI could be funded through savings from averting prisons, emergency care, and homelessness,[12] based on the evidence that high health care spending in the US is a direct result of low social safety net spending.[13] In fact, the significant literature on social determinants of health (SDOH) establishes a direct link between social factors and health status, and some evidence points to a link between social spending and health outcomes.[14] However, it remains unclear exactly how much low spending on

SDOH impacts health spending and therefore how much overall spending could be reduced in a UBI program.

Former 2020 presidential candidate and current New York City mayoral candidate Andrew Yang has run on a platform of a guaranteed income. Yang's proposal, called the Freedom Dividend, suggested giving $1,000 per month to all US citizens over the age of 18 unconditionally. Yang proposed funding his UBI proposal through four sources. First, he proposed streamlining and consolidating several welfare programs. Second, he suggested implementing a Value Added Tax of ten percent to generate revenue. Third, he stated that UBI would put money into the hands of American consumers and would thereby generate economic growth. And fourth, he proposed taxing top earners and pollution through such actions as a financial transactions tax and a carbon fee.[15]

UBI PILOT PROGRAMS AND RESULTS

Manitoba Basic Annual Income Experiment (Mincome)

In 1975, the Canadian government began the Manitoba Basic Annual Income Experiment (Mincome), which lasted three years. The results of this experiment were published in 2011. Unlike most UBI pilots, Mincome allowed researchers to compare the health of those receiving UBI to the health of similar people not receiving UBI. The experiment involved 1,300 urban and rural families with incomes below $16,000 in Canadian dollars for a family of four. Families with higher incomes still received the UBI but at a reduced rate. Therefore, working was still rewarded, and the results of the pilot show that the majority of Mincome participants kept working. Importantly, families receiving the UBI had fewer hospitalizations, accidents, and injuries. Additionally, mental health hospitalizations fell dramatically in the population receiving UBI. Further, the high school completion rate for 16- to 18-year-old boys increased, and adolescent girls were less likely to give birth before the age of 25. The experiment was terminated after three years when Canada's governing party changed midway through the proposed duration of the pilot.[16] To date, Mincome remains one of the few UBI experiments measuring any health outcome related data.

Finland's Basic Income Experiment

In 2017, Finland launched a UBI experiment involving a guaranteed tax-free income of about $590 per month to 2,000 randomly selected unemployed citizens. The trial experiment lasted nearly two years. As researchers explore the effects of the experiment, one general finding is that happiness and overall sense of wellbeing improved. Participants also stated that the income gave them a sense of autonomy and allowed them to return to meaningful activities. Regarding employment, the results are mixed. Employment went up slightly in the second year of the trial but not significantly. Participants stated that there were still no jobs available in the areas in which they were trained. Others noted that, due to the basic income, they were more prepared to take on lower paying jobs to enable them to reenter the workforce.[17]

Ontario Basic Income Pilot

In March 2017, the government of Ontario, Canada began the Ontario Basic Income Pilot. The pilot was undertaken in three sites in Ontario with 4,000 low-income individuals participating with an additional 2,000 people participating in the comparison group. The participants were eligible to receive up to $16,989 per year for a single person, less 50 percent of any earned income or up to $24,027 per year for a couple, less 50 percent of any earned income. The pilot measured, among other markers, food security, stress and anxiety, mental health, housing stability, and health and

health care usage. Additionally, participants receiving support through social assistance needed to withdraw from those programs to participate and receive the UBI. In 2019, Ontario terminated the pilot earlier than planned two months after a change in the control of the province's government from the Liberal Party to the Progressive Conservatives Party. The new government stated that winding down the pilot will enable participants to transition back to more proven support systems without putting an undue burden on taxpayers.

Stockton Economic Empowerment Demonstration

In February 2019, the city of Stockton, California began giving 125 city residents a guaranteed income of $500/month for 18 months.[18] The monthly income was unconditional, and it was intended to test UBI as a solution to poverty and inequality. Though the program was scheduled to end in June 2020, it was renewed until January 2021 due to the COVID-19 pandemic. The 125 residents participated in individual onboarding appointments, which included informed consent and benefits counseling. According to the Stockton Economic Empowerment Demonstration (SEED), the purpose of the benefits counseling was to ensure that the participants were aware of any risks associated with the UBI disbursements possibly impacting their health insurance or other benefits such as food stamps or Supplemental Security Income. One of the primary outcomes that the SEED researchers planned to measure was the effect of the UBI on the participants' functioning and well-being. One of the early program results observed was that most recipients spent their money on groceries and utility bills. In the early phase of the program, food spending made up about 30 percent to 40 percent of the spending each month. However, after the pandemic started, the share of food spend increased to almost 50 percent.[19] After initial results were released, a group of mayors announced the formation of the Guaranteed Income Coalition, which is committed to investigating how to successfully build and launch UBI projects in their cities.

In March 2021, SEED released the results from the first year of the experiment. A primary finding is that the individuals who received the monthly UBI payment secured fulltime employment at more than twice the rate of those in the control group. Additionally, within a year, the proportion of recipients receiving the cash payments who had a fulltime job went from 28 percent to 40 percent. Meanwhile, the control group saw a 5 percent increase in full time employment. Another positive finding is that those receiving cash payments reported being less anxious and depressed compared to the control group. As far as how the group spent the money, of the money tracked, recipients spent more on necessities like food (37 percent), home goods and clothes (22 percent), utilities (11 percent), and car costs (10 percent). The recipients spent less than 1 percent of the UBI payment on alcohol or cigarettes. Although the study's sample size is small, the early results indicate that UBI payments give recipients stability and enhance health.[20] [21]

OpenResearch

Another UBI pilot being undertaken is by OpenResearch, a non-profit research lab. The study, which started in 2020, recruited about 3,000 people across two states. It randomly assigned 1,000 of those individuals to receive $1,000 per month for three years while using the other 2,000 individuals as the control group. Importantly, the pilot will measure health outcomes including health markers (e.g., body mass index, hypertension), healthy behaviors, health insurance coverage, food security, housing quality and stability, physician and mental health care utilization, crime victimization, and mental health.

RELEVANT AMA POLICY

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to provide leadership in addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

The AMA also has strong policy supporting Medicaid. Policy H-290.986 states that the Medicaid program is a safety net for the nation's most vulnerable populations. Moreover, the AMA is committed to expanding Medicaid coverage. In particular, Policy D-290.979 directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. Finally, Policy D-290.985 encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.

DISCUSSION

There are risks to replacing targeted social safety net programs, which protect the most vulnerable, with a UBI program. The AMA strongly supports these existing evidence-based safety net programs. Of note, AMA Ethics Opinion 11.1.1 states that health care is a fundamental human good and the Council believes physicians have a responsibility to work to ensure access to care. The Council advises caution regarding support for any proposal that may have the effect of jeopardizing access to care.

The AMA continues to advocate for Medicaid funding and other safety net program funding. Medicaid and other safety net programs increase vital access to care for patients, reduce the number of uninsured individuals, and improve the lives of working Americans. The Council believes the AMA should continue its efforts to improve upon and expand Medicaid and other programs that improve the health of patients. Therefore, the Council recommends reaffirming the AMA's comprehensive policy on addressing health disparities, the role of Medicaid as a vital safety net program, the AMA's enduring commitment to expanding Medicaid eligibility, and sufficient funding for the program.

An evidence-based method to analyze UBI is currently unavailable. Models have been population-based and generally do not meet minimum standards for randomized control studies. They have also been subject to political influence and change. Experiments are key to understanding how and if UBI would work on a large scale. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects the program would have once implemented. The Council does not believe that there are adequate data to actively support UBI pilots at this time. However, the Council recognizes that UBI may be one of myriad solutions to help address growing inequity and health care disparities. Therefore, the Council recommends that the AMA

actively monitor UBI pilots moving forward, especially pilots that intend to measure the health outcomes and access to care of its participants.

The Council understands that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. Since February 2020, governments all over the world, including the US, have started distributing direct cash payments among large portions of their populations in order to mitigate the loss of jobs and financial disruption of the pandemic. A report from the United Nations recently stated that temporary basic income payments could stem the spread of the pandemic by enabling workers, particularly those living below the poverty line, to stay at home.[22] Additionally, Spain started a UBI program offering monthly payments up to $1,145 to its poorest families in 850,000 households. The program is the largest test of UBI seen thus far. The program is seen as a way to not only soften the impact of the COVID-19 pandemic but also to become a structural instrument of stability in the country. Also, in March 2021, Congress passed, and the president signed into law the third pandemic aid package that once again includes direct payments to millions of Americans. Importantly, the law, the American Rescue Plan, substantially expands the Child Tax Credit and supplements the earnings of families receiving the credit. Under the law, most Americans will receive $3,000 a year for each child ages 6-17, and $3,600 per year for each child under 6. The provision lasts one year and will be sent via direct deposit on a "periodic" basis. This provision represents a major expansion of the child tax credit, and the proposed "periodic" payments mirror a UBI payment.[23]

As the COVID-19 pandemic and its economic fallout continue, the US and society must consider the appropriate responses to not only the pandemic but also deepened and newly exposed financial inequities. The AMA is committed to following and analyzing the relevant research to confront these issues and propose solutions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)

5. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action)

Fiscal Note: Less than $500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-JUN-21

Subject: Promoting Accountability in Prior Authorization

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates adopted Policy D-320.983, which asks that the American Medical Association (AMA) study the frequency by which health plans and utilization review entities are using peer-to-peer (P2P) review prior authorization (PA) processes, and the extent to which these processes reflect AMA policies, including H-285.987, "Guidelines for Qualifications of Managed Care Medical Directors," H-285.939, "Managed Care Medical Director Liability," H-320.968, "Approaches to Increase Payer Accountability," and the AMA *Code of Medical Ethics* Policy 10.1.1, "Ethical Obligations of Medical Directors," with a report back to the House of Delegates.

This report provides background on PA, an overview of the P2P PA process, outlines the significant AMA advocacy efforts on PA and utilization management (UM) review, and proposes recommendations to strengthen AMA policy on PA and, in particular, P2P reviews.

BACKGROUND

Health plans employ PA, step therapy, and other forms of UM to control access to certain treatments and reduce health care expenses. The medical literature clearly establishes the time and cost burdens associated with UM requirements on physician practices. UM often involves manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care. More importantly, PA and other UM methods interfere with patients receiving timely and optimal treatment selected in consultation with their physicians. At the very least, UM requirements can delay access to needed care. In some cases, the barriers to care imposed by UM may lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful therapies.

PEER-TO-PEER REVIEWS

P2P conversations refer to discussions between a physician and an insurance company physician employee. The discussion generally occurs after an initial PA denial that typically involves questions of medical necessity or treatment requests that are considered investigational. However, numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs. The rationale behind P2P is to provide a more transparent PA process that is collaborative and appropriately follows relevant clinical guidelines. However, for many treating physicians, P2P review simply represents another time-consuming and potentially detrimental use of UM by insurance companies. Peer reviewers can be unqualified to assess the need for services for an individual patient for whom they have minimal information and have never evaluated or spoken with. These issues are exacerbated if physicians are required to participate in P2P for first-line PAs.

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RELEVANT AMA ADVOCACY

PA and other UM programs are a high-priority advocacy issue for the AMA. Several current AMA initiatives address the concerns raised in Policy D-320.983 and strengthen the AMA's ability to effectively advocate on UM issues:

1. State Legislative Activity: In response to the numerous concerns raised by AMA members and the Federation of Medicine, the AMA's Advocacy Resource Center works closely with state and specialty medical societies to address PA and other UM-related issues through state legislation. The AMA's model bill on PA, the "Ensuring Transparency in Prior Authorization Act," addresses a variety of concerns related to UM programs, including response timeliness, duration of authorizations, public reporting of UM program results, retroactive denials, and electronic PA. Additionally, the bill states that UM staff have experience treating patients with the medical condition or disease for which the health care service is requested.[1] At the time of writing, there were nearly 40 bills related to PA and step therapy in the state legislatures, several of which are broad reform efforts based on the AMA model bill, as well as several directed at reducing UM requirements for individuals with HIV/AIDS, cancer, substance use disorder and other chronic diseases and conditions. Additionally, as part of the state policymakers' responses to COVID-19, commercial plans and Medicaid in many states were required (or urged) to reduce certain UM requirements to ensure safe access to care during state stay-at-home orders and other restrictions.

2. Prior Authorization and Utilization Management Reform Principles: To improve access to care and reduce practice burdens, the AMA convened a workgroup of state and specialty medical societies, national provider associations, and patient representatives to create a set of best practices related to PA and other UM requirements. The workgroup identified the most common provider and patient complaints associated with UM programs and developed the Prior Authorization and Utilization Management Reform Principles to address these priority concerns. These 21 principles seek to improve PA and UM programs by addressing the following 5 broad categories of concern:

    a. Clinical validity
    b. Continuity of care
    c. Transparency and fairness
    d. Timely access and administrative efficiency
    e. Alternatives and exemptions

    These "best practice" principles have served as the foundation for an extensive, multi-pronged advocacy campaign to reform and improve UM programs. Workgroup members directly advocate with health plans, benefit managers, and other UM entities to voluntarily adopt these principles; urge accreditation organizations, such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria for utilization review programs; introduce bills based on these principles to state legislatures; encourage technological standards organizations to support improved UM processes; and launch a media campaign to raise awareness of the principles and requested reforms.

    Additionally, two of the PA principles specifically reference the qualifications that health plan reviewers should possess. Principle 3 states that utilization review entities should offer an appeals system for their UM programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/sub-

specialty for discussion of medical necessity issues. Principle 16 states that, should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Moreover, providers and patients should be notified of decisions on all other appeals within ten calendar days. And all appeal decisions should be made by a provider who is not only of the same specialty and subspecialty, whenever possible, as the prescribing/order physician, but also, the reviewing provider must not have been involved in the initial adverse determination.[2]

3. The Consensus Statement on Improving the Prior Authorization Process: The release of the 21 PA reform principles initiated meaningful discussions with the health insurance industry about reducing PA burdens. These discussions led to the development of the Consensus Statement on Improving the Prior Authorization Process—created by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, BlueCross BlueShield Association and Medical Group Management Association. The AMA continues to advocate for insurers to operationalize the concepts outlined in the Consensus Statement in their PA programs.[3]

4. Prior Authorization Research: The lack of alignment between physician and health plan interests on PA and other UM programs creates significant challenges in achieving meaningful reform on this issue. Recognizing the key role that credible evidence plays in successful advocacy on this topic, the AMA is engaged in research to gather data regarding the impact of PA on patients and physician practices, including an annual physician survey assessing the burdens associated with UM programs.

   PA Physician Survey – In conjunction with a market research partner, the AMA fielded a web-based survey of 1000 practicing physicians in December 2019. The survey sample comprised 40 percent primary care and 60 percent specialty physicians and only included physicians who provide at least 20 hours of patient care during a typical week and routinely complete PAs in their practice. Along with gathering data on the impact of PA on both patient access to timely care and practice burdens, the survey also assessed physicians' perception of the frequency of P2P review requirements and the qualifications of insurer "peers."

   One survey question asked physicians: "How often are you involved in a peer-to-peer review during the prior authorization process?"

   - Never – 6%
   - Rarely – 30%
   - Sometimes – 45%
   - Often – 15%
   - Always – 3%
   - Don't know – 1%

   Another survey question asked physicians: "How has the frequency of peer-to-peer reviews during the prior authorization process changed over the last five years?"

   - Increased significantly or increased somewhat – 60%
   - No change – 35%
   - Decreased somewhat or decreased significantly – 5%

An additional survey question asked physicians: "When completing a peer-to-peer review during the prior authorization process, how often does the health plan's 'peer' have the appropriate qualifications to assess and make a determination regarding the prior authorization request?"

- Always – 2%
- Often – 13%
- Sometimes – 41%
- Rarely – 28%
- Never – 4%
- Don't know – 11%

Note: Percentages do not sum to 100 percent due to rounding.

DISCUSSION

The Council recognizes the value and importance of the AMA's current multi-pronged advocacy efforts related to PA and applauds the House of Delegates for highlighting the issue of P2P PA and its effect on physicians and most importantly patients. To continue its effective advocacy efforts regarding PA, the Council recommends reaffirming several AMA policies and recommends a number of new policies specifically related to P2P PA. First, the Council recommends reaffirming Policy H-320.939, which states that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

Additionally, the Council recommends reaffirming Policies H-320.948 and H-320.961, which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. Further, the Council recommends reaffirming Policy H-320.949, which states that UM criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions, and Policies H-285.998 and H-320.945, which further underscore the importance of a clinical basis for health plans' coverage decisions and policies.

While physicians have the freedom to choose their method of making a living, physicians employed by insurance companies must not have their ethical obligations discharged. Insurance companies know that many patients and physicians do not appeal PA decisions, and even fewer seek an external review. However, when an external review is sought, nearly one-third of external reviews of insurer denials are overturned.[4] These overturned denials demonstrate that insurers' processes for determining medical necessity often do not reflect current clinical standards of care. It is imperative to patient safety and quality of care that physicians make utilization review decisions in good faith and follow evidence-based guidelines in their work for insurers. Therefore, the Council recommends reaffirming Policy H-285.939, which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services.

Furthermore, the Council recommends addressing the timeframe for PA decisions for P2P discussions. Physicians generally receive the PA decision at the end of the P2P discussion. However, insurers have suggested that plans should have two business days after the P2P to make a decision. A recent operating rule for electronic PA has this longer specification. Specifically, it states that once a health plan receives a complete PA request, including any P2P medical reviews conducted, the health plan must return an approval or denial to such request within two business days.[5] Further delaying the PA determination harms all patients and has a disproportionately negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA decisions be made at the end of the P2P review discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. The Council believes such mitigating circumstances include instances wherein a physician involved in the P2P discussion requests additional time to read relevant medical literature. Importantly, the Council notes that such an extension shall not be permitted where the PA request is urgent.

As highlighted in Policy D-320.983, care must be taken to ensure that plan reviewers are, in fact, physician peers with the appropriate experience treating the condition in question and from the same specialty or subspecialty. The AMA already has strong policy stating that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review (e.g., Policy H-320.968). Nevertheless, the Council believes that policy should be strengthened to ensure that not only is the reviewing physician of the same specialty and licensed to practice in the jurisdiction, but also has the expertise to treat the medical condition or disease under review according to up-to-date evidence-based guidelines and has knowledge of novel treatments.

Moreover, as directed by Policy D-320.983, the Council highlights Ethics Opinion 10.1 regarding ethical guidance for physicians in nonclinical roles. Ethics Opinion 10.1 states that physicians earn and maintain the trust of their patients and the public by upholding norms of fidelity to patients, on which the physician's professional identity rests, and that, despite not directly providing care to patients, physicians employed by insurers have committed themselves to the values and norms of medicine. Accordingly, the Council recommends that physicians employed by insurance companies must follow current evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.

The Council notes that the AMA's efforts to reduce PA burdens are particularly important during public health emergencies, such as the novel coronavirus (COVID-19) pandemic. Recognizing the enormous strain placed on physicians and the entire US health care system and, more importantly, the impact that delayed care has on patients during the COVID-19 crisis, the AMA and other organizations have successfully advocated for many commercial health plans to temporarily suspend or otherwise adjust PA requirements. Meanwhile, legislators and regulators have reduced PA in both the commercial and Medicaid markets via legislation, executive orders, and waivers. While the AMA strongly supports relaxation in PA requirements during the COVID-19 emergency, there is considerable variation in the adjustments being made across the commercial health insurer market and corresponding effective dates, with some plans quickly reinstating regular PA processes only a few months into the pandemic. The AMA is tracking individual health plan COVID-19-related PA program updates to help physicians stay informed of these rapidly changing policies (see https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf). To that end, the Council recommends that the AMA urge temporary suspension of all prior authorizations and calls for the extension of existing approvals during a declared public health emergency.

Finally, the Council notes that PA remains a top-of-mind issue for physicians and, as such, deserves substantial AMA attention and resources. As detailed in this report, the AMA prioritizes

PA as one of its key advocacy issues and continues to collaborate with relevant stakeholders to address physician concerns on this topic. The AMA is committed to ensuring that tackling PA and UM issues will continue to be a leading priority for the AMA.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans' coverage decisions and policies. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services. (Reaffirm HOD Policy)

6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. (New HOD Policy)

7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. (New HOD Policy)

8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable. (New HOD Policy)

9. That our AMA continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency. (New HOD Policy)

10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-JUN-21

Subject: Medical Center Patient Transfer Policies (Resolution 818-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Interim Meeting, the House of Delegates referred Resolution 818, which was sponsored by the Organized Medical Staff Section. Resolution 818-I-19 asked the American Medical Association (AMA) to: (1) study the impact of "auto accept" policies (i.e., unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients; and (2) advocate that if a medical center adopts an auto accept policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff. Reference Committee J from the 2019 Interim Meeting noted that the resolution simultaneously called for study and new policy, and it emphasized the importance of first studying the issue of auto accept policies. Accordingly, this report explores patient transfer issues, with consideration of potential clinical and financial impacts on patients, and legal, accreditation, and medical staff bylaws implications for physicians and medical centers.

BACKGROUND

Optimal patient health and well-being should be the principal goals of patient transfer, but disagreements can arise in pursuing those goals. Some physicians have observed that medical centers where they practice can automatically accept the transfer of patients with emergent and/or serious conditions, and they have voiced concern that accepting transfer patients without adequate input from the medical staff could jeopardize patient care. The term "auto accept policies" encompasses a variety of medical center policies that address how patients may be "automatically" received at their institutions. For example, one large public health system has implemented an auto accept policy whereby critical care nurses answer phone calls from transferring physicians and accept patient transfers instantaneously--transfer requests are not denied.[1] As part of this system, physicians are paid to be on call and to receive patients from the region. Another medical center will automatically accept any acute critical transfer, with a specially educated triage registered nurse gathering clinical and basic demographic information, locating an accepting physician, and arranging for a bed in the appropriate level of care that will be ready when the patient arrives.[2] As a third example, another medical center has a pilot program to automatically accept into their Emergency Department (ED) stable patients from other medical centers who need specific services.[3] These varied auto accept policies highlight the challenges that are inherent in transferring patients among medical centers and the critical role that physicians must play in these processes.

Any time a patient is transferred from one facility to another, it is essential that both transferring and receiving facilities ensure that there is an accepting physician who is capable of taking responsibility for the care of the transferred patient, and medical centers receiving a transferred patient must affirmatively accept the patient. Under certain conditions, acceptance will be

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mandatory. Nevertheless, medical center transfer policies, including auto accept policies, that fail to identify the appropriate physicians and their capabilities run the risk of suboptimal care for the patient and delays while the appropriate physicians and resources are identified. In addition, transfers of patients with emergent and/or serious conditions carry implications not only for individual patients, but also public health and legal implications for individual physicians and medical centers, so patient transfer policies must address all of these implications.

KEY CHALLENGES ARISING WITH PATIENT TRANSFERS

Interhospital transfer is an understudied area, with little known about institutional variations in information transfer and impacts on patient outcomes.[4] A recent survey of 32 tertiary care centers in the United States studied communication and documentation practices during interhospital patient transfers and found that practices vary widely among tertiary care centers, and the level of transfer center involvement in oral and written handoff was inconsistent.[5] Moreover, patients may be transferred from one medical center to another for a variety of reasons, including to receive specific expert medical services such as monitoring, tests, or procedures, or to accommodate patient or family preference.[6] With a variety of specialists involved in the care of patients with emergent and/or serious conditions requiring transfer, communication and coordination are critical, but complicated.[7] Often, the physicians who will be directly caring for a transferred patient want to be involved early in the transfer process to ensure that their specific questions are answered.[8] In an attempt to address transfer challenges, some hospitals have established dedicated call centers, often staffed by senior-level nurses, to coordinate communication between accepting and receiving physicians.[9] However, studies have found such call centers to be highly variable in their functionality and effectiveness.[10]

Non-medical factors have been found to influence decisions regarding whether a stable patient will be transferred to another facility for inpatient care, but again, the impact on quality of care is unknown. An analysis of all-payer administrative data from a representative sample of community hospitals in the United States found that uninsured patients and women were significantly less likely to be transferred to another acute care hospital.[11] The study authors were surprised to find the lower rate of transfer for uninsured patients, expecting that a hospital would seek to transfer uninsured patients as soon as they fulfilled their EMTALA obligations. Instead, the study authors suspected that the lower transfer rates for uninsured patients can be explained by an unwillingness of receiving hospitals to accept uninsured transfer patients. At the same time, the study authors emphasized that economic factors are unlikely to explain the lower transfer rates they found for women, and they expressed concern for the potential of implicit or explicit biases contributing to this disparity. Critically, though, it is unknown whether the differences in transfer patterns identified in this study led to differences in health outcomes.

Hospitals' interfacility transfer agreements and protocols can impact patient care not only within inpatient departments, but in the ED as well. To the extent that inpatient beds are reserved for specific categories of patients, including interfacility transfer patients, challenges can arise when there are insufficient inpatient beds available to receive transfers from the medical center's ED.[12] Patients who stay in the ED for longer than the time required for a "timely transfer" to an inpatient bed are considered "boarders," and challenges surrounding boarding patients in the ED are well-established.[13] (Definitions of "timely transfer" vary, but experts often look for a period of less than two hours from the admission order.) Boarding can exacerbate health disparities, with Black, female, elderly, and psychiatric patients being more likely to board for longer periods of time.[14] Moreover, patients with medically treated conditions are more likely to board than those with surgically treated conditions.[15] With the ED being the dominant source of hospital admissions,[16] it is critical for medical center transfer policies to promote optimal care for the patients who present

with emergent and/or serious conditions, both before and after their stabilization. The problems associated with patient boarding are so severe, there is evidence that they increase in-hospital death rates substantially.[17] Reflecting these problems, The Joint Commission (TJC) imposes requirements that hospitals address boarding for purposes of accreditation.[18] Importantly, reservation of inpatient beds for interfacility transfer patients is just one factor contributing to the complex challenge of ED boarding, and solving the broader issue of ED boarding is beyond the scope of this report.

When contemplating the transfer of a stable patient who is not receiving care in an ED, in addition to the critical clinical implications of the transfer, patient financial impacts must also be considered. Prior to transferring a patient to a new medical center, it is important to consider whether the new facility is in-network under the patient's health plan. If the intended transfer facility is out-of-network (OON), the patient and/or family will need to be prepared for the financial implications of receiving OON care. Additionally, if the patient is receiving, or intends to receive, care that requires prior authorization (PA), it is important to recognize that site of service can be an essential element of PA approval,[19] so a service approved at an originating facility may require reapproval for a new site of service. Transfer decisions should include a patient-centered discussion between a patient and/or family and a referring physician that addresses the various potential merits and risks of undergoing a transfer.[20]

The novel coronavirus (COVID-19) pandemic has posed unprecedented challenges, including managing patient transfers. Geographically localized surges in COVID-19 cases put extreme pressure on local health care facilities, as hospitals strive to transfer COVID-19 patients to sites where they can receive optimal care and/or transfer non-COVID-19 patients out of their facility to protect uninfected patients and free up resources to care for more COVID-19 patients.[21] State and local emergency medical planners have taken a variety of approaches in rising to meet the pandemic's challenges, and the Centers for Disease Control and Prevention (CDC) has issued guidance around patient safety and relief for health care facility operations.[22] The CDC emphasizes the importance of communication between health care professionals at both the transferring and receiving facilities with accurate clinical descriptions of patients and clear acceptance by receiving facilities.

Balancing the complex considerations surrounding patient transfers, the American College of Emergency Physicians (ACEP) has published guidelines on Appropriate Interfacility Patient Transfer, and AMA policy (Policies H-130.982 and H-130.961) expressly supports these guidelines. Key elements of the ACEP guidelines specify, "The medical facility's policies and procedures and/or medical staff bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital . . . Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of the transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer. When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place."[23] These guidelines, developed by subject matter experts and supported by the AMA, help to ensure that high quality patient care drives interfacility patient transfers, with physician input into the decision-making process.

EXTERNAL FACTORS SHAPING PATIENT TRANSFER POLICIES

Medical centers' ability to implement transfer policies such as the auto accept policies described in Resolution 818-I-19 is influenced by a number of external factors, including Medicare Conditions

of Participation (COPs), accreditation standards, medical staff governing documents, and in certain cases, state and/or federal law. Medicare COPs govern patient transfer in the context of discharge planning, requiring that hospitals transfer or refer patients to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.[24] Moreover, Medicare COPs make clear that the medical staff "is responsible for the quality of medical care provided to patients by the hospital,"[25] and TJC provides an accreditation framework to guide medical center and physician collaboration. As outlined by TJC, "The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process."[26] Additionally, for a medical center's "governing body to effectively fulfill its accountability for the safety and quality of care, it must work collaboratively with the medical staff leaders toward that goal."[27] While accreditation standards do not have the force of law, TJC's long history of hospital accreditation and its recognition by federal and private payers have made its standards nationally accepted practices.[28] Additionally, medical staff documents including bylaws, rules and regulations, and policies govern the relationship between medical centers and their medical staff. The bylaws describe the rights, responsibilities, and accountabilities of the medical staff and specify how the organized medical staff works with and is accountable to the governing body. Medical staff rules and regulations usually address patient care issues across the organization and typically contain provisions about patient transfers.[29]

As the sponsors of Resolution 818-I-19 indicate, EMTALA provides a legal framework for many interhospital transfers, with specific mandates for both facilities and physicians. EMTALA was established as federal law in 1986, and many states have related laws and regulations that impose additional duties on hospitals and physicians.[30] EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without minimally providing a medical screening examination to ensure the patients were stable for transfer. Additionally, under EMTALA, hospitals with specialized capabilities must accept patient transfers from hospitals that lack the capability to treat unstable emergency medical conditions, and EMTALA transfer obligations apply, even under the extraordinary circumstances posed by COVID-19.[31] However, EMTALA does not apply to the transfer of stable patients. Importantly, both hospitals and physicians can be penalized for EMTALA violations, with penalties including termination of the hospital or physician's Medicare provider agreement and fines of up to $104,826 per violation.[32] With both the hospital and the physician individually liable under EMTALA, it is critical that both work together to ensure that patient transfers further the shared goal of optimal patient care.

RELEVANT AMA POLICY

AMA policy directly responds to the resolves of referred Resolution 818-I-19. First, a comprehensive array of policy guides collaboration between medical centers and medical staff. Policy H-225.957 sets forth principles for strengthening the physician-hospital relationship, emphasizing the interdependence between the organized medical staff and the hospital governing body, while highlighting the medical staff's role in quality-of-care issues. Similarly, Policy H-225.971 provides a strong framework for how hospitals and medical staff ought to collaborate and articulates the primary role of the medical staff on matters of quality of care and patient safety. In addition, Policy H-225.942 provides a set of physician and medical staff member bill of rights, which include the right to be well-informed and share in the decision-making of the health care organization's operational and strategic planning. Finally, Policy H-225.961 states that in crafting medical staff development plans, hospitals/health systems should incorporate the principles that the medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including in developing operational plans, service design, resource allocation, and organizational policies. The policy further insists that the medical staff must ensure that quality patient care is not harmed by economic motivations.

Long-standing policy also guides the transfer of patients among medical centers. Policy H-130.982 provides principles to guide interfacility transfers of unstable emergency patients, detailing the critical roles of both the transferring and receiving physicians and endorsing ACEP's Appropriate Interfacility Patient Transfer guidelines. Similarly, Policy H-130.961 also endorses the ACEP guidelines, encouraging county medical societies and local hospitals to review and utilize the ACEP guidelines as they develop local transfer arrangements. In addition, Policy H-130.965 supports working with the American Hospital Association (AHA) to develop model agreements for appropriate patient transfer.

Finally, AMA policy and advocacy strive to protect patients and physicians facing burdens from health plan OON restrictions and PA requirements. Policy H-285.904 sets forth principles related to unanticipated OON care, and Policy H-320.939 details the AMA's position on PA and utilization management (UM) reform.

In addition to AMA policy, AMA ethics opinions also guide physicians and medical centers as they refine patient transfer policies. *Code of Medical Ethics* Opinion 9.5.1 guides the relationship between an organized medical staff and hospital and establishes that the core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.[33] Additionally, *Code of Medical Ethics* Opinion 9.4.2 provides a series of steps physicians should take if they become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards.[34]

DISCUSSION

The Council thanks the sponsors of Resolution 818-I-19 for highlighting the critical intersection of medical center transfer policies with quality of care, public health, legal/regulatory, and medical staff concerns. Existing AMA policy lays the groundwork to protect patients and physicians in the context of patient transfers, and this policy can be expanded. First, the Council recommends amending Policy H-130.982, changing the title of the policy and broadening the language used, so that this long-standing policy guiding the transfer of emergency patients would apply to protect all transferred patients. Similarly, the Council recommends building upon the strong policy that establishes a physician and medical staff member bill of rights and outlines the rights and responsibilities of organized medical staff. Policy H-225.942 emphasizes the importance of physicians' treatment decisions remaining insulated from commercial or other motivations that could threaten high-quality patient care and the medical staff's responsibility to participate in the health care organization's operational and strategic planning to safeguard the interests of patients, the community, the health care organization, and the medical staff and its members. The policy also outlines medical staff rights, including the right to be well-informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, or close medical staff departments. The Council recommends amending Policy H-225.942 to articulate the medical staff's right to be well-informed and share in the decision-making regarding transferring patients into, out of, or within the health care organization. Additionally, the Council recommends amending Policy H-130.965 to support working with both the AHA and other interested parties to develop model agreements for appropriate patient transfer.

Finally, recognizing the significant patient, physician, and medical center time and talent involved in obtaining PA approval, the Council believes that when circumstances (such as the site of service) change, the PA process should support revisions to pending or existing approvals rather than require re-initiation of the PA request. In articulating the AMA's position on PA and UM

reform, Policy H-320.939 emphasizes that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care. Building upon this strong advocacy position, the Council recommends amending Policy H-320.939 by adding a new section four stating that health plans should minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending PA requests.

The Council also recommends reaffirming several policies that address key concerns raised by Resolution 818-I-19. Speaking to physician and medical staff roles in decision-making regarding patient transfers, Policy H-225.957 provides principles for strengthening the physician-hospital relationship. Policy H-225.957 emphasizes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff and sets forth parameters for collaboration and dispute resolution between the medical staff and hospital governing body. In addition, Policy H-225.971 details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing and reaffirms TJC standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges." Moreover, the policy states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. Reaffirming these policies underscores the AMA's longstanding and continuing commitment to productive collaboration between physicians and medical centers in developing patient transfer practices that are focused on providing high-quality patient care. Finally, the Council recommends reaffirming Policy H-285.904, which sets forth principles to protect patients receiving unanticipated OON care. Policy H-285.904 states that patients must not be financially penalized for receiving unanticipated care from an OON provider; insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties; and patients who are seeking emergency care should be protected under the "prudent layperson" legal standard, without regard to PA or retrospective denial for services after emergency care is rendered.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:

   H-130.982 Interfacility Patient Transfers ~~of Emergency Patients~~
   Our AMA: (1) supports the following principles for ~~the~~ interfacility patient transfers ~~of emergency patients~~: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer ~~of an unstabilized emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical ~~service~~ care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers ~~of emergency patients~~ should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician

organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to physician organizations that are ~~their county medical societies as they~~ developing such protocols and interhospital agreements with their local hospitals. (Modify Current HOD Policy)

2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows:

   d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, ~~or~~ close medical staff departments, or to transfer patients into, out of, or within the health care organization. (Modify Current HOD Policy)

3. That our AMA amend Policy H-130.965 by addition as follows:

   Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Modify Current HOD Policy)

4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:

   4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to unanticipated out-of-network care. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Appendix: Policies Recommended for Amendment or Reaffirmation

H-130.965 Refusal of Appropriate Patient Transfers
Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Sub. Res. 155, I-89Reaffirmed: Sunset Report and Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 01, A-20)

H-130.982 Transfer of Emergency Patients
Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhopsital agreements with their local hospitals.
(CMS Rep. H, A-86Reaffirmed: BOT Rep. BB, A-90Reaffirmed: CMS Rep. F, I-92Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Modified: CMS Rep. 01, A-20)

H-225.942 Physician and Medical Staff Member Bill of Rights
Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:
Preamble
The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.
The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can

physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.
From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.
II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.
III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:
a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
(BOT Rep. 09, A-17Modified: BOT Rep. 05, I-17Appended: Res. 715, A-18Reaffirmed: BOT Rep. 13, A-19)

H-225.957 Principles for Strengthening the Physician-Hospital Relationship
The following twelve principles are AMA policy:
PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP
1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self-govern, as that authority is set forth in the governing documents of the organized medical staff. The organized

medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self-governance, which include but are not limited to:
a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality-of-care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.
(Res. 828, I-07Reaffirmed in lieu of Res. 730, A-09Modified: Res. 820, I-09Reaffirmed: Res. 725, A-10Reaffirmation A-12Reaffirmed: CMS Rep. 6, I-13)

H-225.971 Credentialing and the Quality-of-Care
It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges"; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and

credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.
(BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13)

H-285.904 Out-of-Network Care
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Mediation should be permitted in those instances where a physician's unique background or skills (e.g., the Gould Criteria) are not accounted for within a minimum coverage standard.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.
Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19

H-320.939 Prior Authorization and Utilization Management Reform
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA

research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-JUN-21

Subject: Urgent Care Centers

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

Similar to retail health clinics, urgent care centers (UCC) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public's desire and expectation of prompt, available, and convenient care.[1] The Council noted that American Medical Association (AMA) policy is largely silent on UCCs and the extent UCCs should play a role in meeting the health care needs of patients.

This report, initiated by the Council, provides background on UCCs, notes the various types of ownership models, outlines the extent of physician oversight and physician employment in the centers, summarizes relevant policy, and proposes new recommendations that expand upon the current body of policy on stand-alone health care clinics.

BACKGROUND

UCCs are free-standing same-day clinics focused on caring for patients who need expedient medical care but who are not experiencing a life-threatening emergency. In 2019, there were more than 9,600 UCCs in the US, representing a 9.6 percent jump in the number of centers since 2018.[2] They provide unscheduled, episodic care to patients. These centers usually provide services such as treating earaches, fever or flu-like symptoms, and minor burns or cuts. Some centers also have X-ray capabilities but generally have limited laboratory capabilities. Overall, the scope of services offered across UCCs varies. The most common diagnosis at UCCs is an upper respiratory infection.[3] Additionally, the number of stand-alone care settings such as UCCs and retail health clinics continues to grow each year as patients look for and expect timely care and convenience. These settings are usually open daily, evenings, and weekends making them an attractive alternative to primary care physician offices for unplanned visits.

Proponents of UCCs emphasize their role in ensuring access to care for vulnerable populations and patients living in rural areas. However, only about 10 percent of clinics are in rural areas while 75 percent are in suburban areas, and 15 percent are in urban areas. Moreover, the payer mix of UCCs indicates that 55 percent of their patients are covered by private health insurance and 22 percent by either Medicare or Medicaid, 10 percent are paid with cash, and 7 percent are paid via workers' compensation.[4] UCCs usually require upfront payment for services from uninsured patients creating a barrier to care for these patients.

In addition to requiring up-front payment, UCCs are in stark contrast with emergency departments (ED) because they do not have state or federal Emergency Medical Treatment and Labor Act obligations to see, treat, or stabilize patients without regard for the patient's ability to pay.[5]

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URGENT CARE CENTER USE COMPARED TO EMERGENCY DEPARTMENT USE

In addition to convenience, proponents of UCCs state that the centers generate health care system cost-savings. UCCs may be classified as cost-effective if they are used as a substitute for an avoidable ED visit. However, it is estimated that only 3.9 percent of ED visits are considered non-urgent. An additional 24 percent of visits are classified as semi-urgent.[6] Therefore, it seems that the utility of UCCs does not lie in their ability to provide substitutive care.

UCCs also have the potential to divert patients away from their usual source of care or patients might utilize UCCs as their usual source of care. Both situations have the potential to disrupt the patient-physician relationship. There are also worries, in an attempt to save money, insurers are encouraging customers to go to free-standing clinics for care, thereby exacerbating fragmentation. Further, UCCs have the potential to be used as additive, rather than substitutive, care, with a corresponding increase to the cost to the health care system. Accordingly, although UCCs have a role to play in the health care system, it is critical that this role is clearly defined and put into practice to avoid increased health care costs and care fragmentation.

URGENT CARE CENTER OWNERSHIP

Initially, when UCCs started to emerge in the early 2000s, they generally were opened by physicians, physician practices, and medical groups. However, more recently, the proliferation of UCCs has been driven by well-capitalized health systems and investor-owned companies. In 2008, 54 percent of UCCs were owned by physicians. Now, less than 40 percent are owned by physicians. Moreover, while hospitals owned less than 25 percent of UCCs in 2008, hospital ownership grew to 37 percent in 2014. At times, because of a UCC's connection to a hospital, it is effectively treated less as a separate extension of that hospital.[7]

UCC developers and health systems have also started partnering with private equity firms and payers.[8] For example, UnitedHealth Group (UHG) and its Optum medical care services unit purchased MedExpress, a brand of UCCs, in 2015. Over the past five years, MedExpress UCC growth is up 70 percent, with more than 250 UCCs. According to UHG, its significant portfolio of clinics and UCCs will increasingly be "wired together" throughout the country.[9]

PHYSICIAN OVERSIGHT

According to the Urgent Care Center Association of America, about 80 percent of UCCs employ a combination of physicians, physician assistants, and nurse practitioners. The remaining 20 percent of centers employ only physicians. UCCs appear to be largely physician-led, with 94 percent of facilities employing at least one full-time physician.[10] Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians.[11] Physician employment at UCCs tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.[12] Staffing in UCCs contrasts with that in retail health clinics, which rely more heavily on nurse practitioners and physician assistants to provide the majority of care.

RELEVANT AMA POLICY

UCCs are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975, H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the

number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion (Policy H-165.985).

AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06, 5-A-07 and 7-A-17, outlines principles for retail health clinics. The policy proposes that an individual, company, or other entity establishing or operating a retail health clinic must have a well-defined and limited scope of clinical services; use standardized medical protocols derived from evidence-based practice guidelines; establish arrangements by which their health care practitioners have direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care with practicing physicians within the local community; establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic; inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients; use electronic health records (EHRs) as a means of communicating patient information and facilitating continuity of care; and encourage patients to establish care with a primary care physician to ensure continuity of care. Additionally, Policy H-160.921 states that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at retail health clinics.

Council on Medical Service Report 7-A-17 further articulated AMA retail clinic policy (i.e., Policy H-160.921) by supporting that a retail health clinic must help patients who do not have a primary care physician or usual source of care to identify one in the community; must use EHRs to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent; must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information; should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made; should use local physicians as medical directors or supervisors; clinics should neither expand their scope of services beyond minor acute illnesses nor expand their scope of services to include infusions or injections of biologics; and should have a well-defined and limited scope of services, provide a list of services provided by the clinic, provide the qualifications of the on-site health care providers prior to services being rendered, and include in any marketing materials the qualifications of the onsite health care providers. Additionally, Policy H-160.921 supports that the AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed the spending for services that a patient receives at a retail health clinic if the physician could not reasonably control or influence that spending.

The AMA also has established policy that addresses the patient-physician relationship, physician extenders, and continuity of care. The AMA encourages policy development and advocacy in preserving the patient-physician relationship (Policies H-100.971 and H-140.920). The AMA has extensive policy on guidelines for the integrated practice of physicians with physician assistants and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947 encourages physicians to be available for consultation with physician assistants and nurse practitioners at all times, either in person, by phone, or by other means. Policy H-425.997 encourages the development of policies and mechanisms that assure continuity and coordination of care for patients. Finally, the AMA believes that full and clear information regarding benefits and provisions of every health care system should be available to the consumer (Policy H-165.985).

The AMA has extensive policy related to the health care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility for care and advocate that allied health

professionals such as nurse practitioners and physician assistants function under the supervision of a physician (e.g., Policies H-35.970, H-45.973, H-35.989). Policy H-160.912 advocates that all members of a physician-led team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure, and the discretion of the physician team leader. Policy H-160.906 defines "physician-led" in the context of team-based health care as the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of those skills.

LEGISLATIVE ACTIVITY

Early in the emergence of UCCs, state regulation largely focused on defining "urgent care," articulating services included within the definition, and accreditation standards. More recently, as the number of UCCs has increased, states are starting to pursue a more active role in urgent care regulatory oversight. For example, some states give state health agencies the authority to license UCCs.[13]

AMA ACTIVITY

With respect to scope of practice issues, the AMA has established the Scope of Practice Partnership with members of the Federation as a means of using legislative, regulatory, and judicial advocacy to oppose the expansion of scope of practice laws for allied health professionals that threaten the health and safety of patients.

DISCUSSION

The Council believes that UCCs can play a role in meeting the health care goals of high quality, efficient care. Nonetheless, striking a patient-centered balance between the use of UCCs and traditional physician visits, including the ED, requires coordination between the various health care settings. Coordination leads to better outcomes and protects against duplicative care. The Council believes that UCCs can serve as a health care access point when a patient's usual source of care is unavailable. Therefore, in its recommendations, the Council emphasizes that the design and use of UCCs, just like retail clinics, should serve as a complement to, rather than a substitute for, the primary care physician or usual source of care. Accordingly, the Council recommends a set of principles to guide the use of UCCs similar to those on retail health clinics (Policy H-160.921).

The Council recommends that a UCC must help patients who do not have a primary care physician or usual source of care to identify one in the community. Given that it is critical that UCCs take responsibility for ensuring continuity of care, the Council further recommends that UCCs must transfer a patient's medical records to his or her primary care physician or other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving provider is capable of receiving it. Additionally, the Council recommends that UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.

Moreover, it has been shown that policies that support patient-centered medical home activities in UCCs can help protect against fragmentation of care.[14] Accordingly, the Council recommends that UCCs work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made. The Council also notes the importance of the patient-centered medical home (PCMH) and the fact that many physicians are expanding

hours and scheduling to provide patients with enhanced access to care. To underscore the effectiveness of PCMHs and physicians' continued commitment to provide more comprehensive access to care, the Council recommends reaffirming Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology codes, including those that already exist for off-hours services. Physicians spend a significant amount of off-hours time messaging and otherwise communicating with patients, and they should be incentivized and supported to continue doing so.

Additionally, the Council is pleased that the vast majority of UCCs are physician-led, and recommends emphasizing the importance of physician-led care by not only reaffirming Policy D-35.985 advocating for the physician-led team, but also recommending that UCCs use local physicians as medical directors or supervisors. Similarly, the Council recommends reaffirming Policy H-385.926 supporting physicians' choice of practice and method of earning a living.

As previously stated, UCC capabilities range significantly. As such, the Council believes it is imperative that each center have a well-defined and limited scope of clinical services, provide a list of services provided by the center, provide the qualifications of the on-site providers prior to services being rendered, the degree of physician supervision of non-physician providers, and include in any marketing materials the qualifications of the onsite health care providers. Moreover, the Council believes that a physician should not be attributed to the spending for services that a patient receives at a UCC if the physician could not reasonably control or influence that spending.

The Council believes that UCCs can serve as a convenient way for patients to receive medical care that does not require life-saving interventions. However, it is critical that patients understand the limits of UCCs and not confuse them for an ED.[15] Therefore, the Council recommends that UCCs be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or as a way to describe the type of care provided. Further, the Council wholeheartedly supports patient education on the role of alternative sources of care such as UCCs. Patients should be notified if physicians are providing off-hours care and told what to do in urgent situations when their physician may be unavailable. Moreover, patients should be informed of the differences between a UCC and an ED. Additionally, the Council is interested in the volume of patient transfers to an ED after a UCC visit and will monitor this issue.

When health care is provided episodically, opportunities to develop or nurture the patient-physician relationship may be missed. Therefore, it is vital to ensure that there is care coordination between the UCC and a patient's usual source of care. Emphasizing the patient-physician relationship is critical to achieving the quadruple aim. To that end, the Council's recommendations aim to ensure that UCCs can be a modern component of patient-centered care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient's primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy)

5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:

    a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;

    b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;

    c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;

    d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;

    e. UCCs should use local physicians as medical directors or supervisors;

    f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and

    g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy)

6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy)

7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-JUN-21

Subject: Addressing Payment and Delivery in Rural Hospitals

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

Despite legislative advances such as the Affordable Care Act (ACA) and Medicaid expansion bringing insurance coverage and health care accessibility to millions of Americans, rural Americans and the health care system intended to serve them continue to face a health care crisis. By most measures, the health of the residents of rural areas is significantly worse than the health of those in urban areas.[1] Though the American Medical Association (AMA) has policy on stabilizing and strengthening rural health, it does not have policy specifically addressing changes to payment and delivery for rural providers and hospitals to address the growing rural health crisis.

This report, initiated by the Council, provides background on the unique obstacles facing rural hospitals including financial challenges, the rural hospital payer mix, the costs of delivering services in the rural setting, and quality measurement and risk adjustment challenges. The report also details relevant AMA policy and provides recommendations to improve the rural hospital payment and delivery systems.

BACKGROUND

Sixty million Americans, almost one-fifth of the US population, live in a rural area. On average, rural residents are older, sicker, and less likely to have health insurance. They stay uninsured for longer and are less likely than their urban and suburban counterparts to seek preventive services. Moreover, they are more likely than urban and suburban residents to encounter possibly preventable deaths from heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke. Disparities in health outcomes continue to increase for this population compared to those living in urban and suburban areas. Rural residents tend to have higher rates of smoking, hypertension, and obesity. They also report less physical activity and have higher rates of poverty. Rural residents are also more likely to be Medicare or Medicaid beneficiaries. For example, Medicare and Medicaid make up over half of rural hospitals' net revenue.[2,3] Additionally, 45 percent of children in rural areas are enrolled in Medicaid or Children's Health Insurance Program compared to 38 percent of children in urban areas.[4]

Those living in rural areas often must travel long distances to access the emergency department (ED) and physician offices, a barrier to care that can lead to delayed or forgone care, which can worsen their health status and increase the cost of care when they do receive it. They are more likely than urban and suburban residents to say that access to good doctors is a major problem in their community.[5] Rural residents live an average of 10.5 miles from the nearest hospital compared with 5.6 miles and 4.4 miles for those in suburban and urban areas respectively.

From 2018 to 2020, 50 rural hospitals closed, a more than 30 percent increase in the number of closures compared to the 3 years prior.[6] The closure of hospitals was generally preceded by

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financial losses caused by a combination of decreasing rural population and inadequate payments from health insurers. There are more than 2,000 rural hospitals across the country, and more than 800 (40 percent) of them are estimated to be at risk of closing. Most of the hospitals at risk of closing are small rural hospitals serving isolated rural communities.

These hospitals are frequently the principal or sole source of health care in their communities, including primary care as well as hospital services. The closure of these rural hospitals could cause the vulnerable populations they serve to lose access to health care and worsen health disparities.[7] Rural hospitals also have more difficulty attracting physicians of varying specialties, which are essential to providing care to rural populations. Often, when a rural hospital closes, recruiting and retaining physicians in the local community becomes increasingly difficult, and the result is decreased access to care for the surrounding population.[8] In addition, rural hospitals often serve as economic anchors in their communities, providing both direct and indirect employment opportunities and supporting the local economy.[9] Rural hospitals are hubs of employment, public health, and community outreach initiatives.[10] Their closure puts the already vulnerable populations they serve at increased risk of losing access to health care, worsening health disparities, and negatively impacting the economy of the local area.[11]

Meanwhile, the novel coronavirus (COVID-19) pandemic has highlighted the fragility of the rural health system and increased the financial threat to an unstable system. All hospitals experienced lower revenue due to canceled elective procedures and some routine care, while simultaneously facing higher expenses due to supplies, equipment, and staff to care for COVID-19 patients. Unlike large urban hospitals, small rural hospitals do not have financial reserves that they can use to cover these higher costs and revenue losses. Rural patients are also more likely to experience more severe impacts from COVID-19 because they are more likely to be obese and have chronic conditions such as diabetes and hypertension.[12] Temporary federal assistance during the pandemic helped many rural hospitals avoid closure during 2020, but the underlying financial problems may cause an increase in closures after the public health emergency ends. The financial impact of the pandemic on individuals living in rural areas has been significant, as many may have experienced unemployment or under employment on hourly jobs with limited benefits.

IMPACT OF PAYER MIX

A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at urban hospitals.[13] While having a high proportion of Medicare patients would be viewed as financially problematic at large hospitals, for many small rural hospitals, Medicare is their “best” payer because Medicare explicitly pays more to cover the higher costs of care in small rural hospitals.

About 75 percent of rural hospitals are classified as Critical Access Hospitals (CAHs), which provides cost-based payment for services provided to Medicare beneficiaries. To be designated as a CAH, a hospital must meet a set of criteria including but not limited to being located either more than 35 miles from the nearest hospitals (or CAH) or more than 15 miles in areas with mountainous terrain; maintain no more than 25 inpatient beds; furnish 24-hour emergency care 7 days a week; and operate a psychiatric or rehabilitation unit of up to 10 beds.[14] It is important to note, however, that CAH payments apply only to beneficiaries with traditional Medicare, not those with private Medicare Advantage (MA) plans.

Most small rural hospitals lose money on Medicaid patients, but in some states, small rural hospitals also receive cost-based payments for Medicaid patients, and some states provide special subsidies to offset losses on Medicaid and uninsured patients.

For many small rural hospitals, the leading cause of negative margins is insufficient payment from private health insurance plans and MA plans. Many private health insurance plans pay less than the cost to deliver essential services in small rural hospitals, whereas private plan payments at most large hospitals are higher than the cost of delivering services.[15] Although most hospitals lose money on Medicaid and care to the uninsured, larger hospitals can use profits on privately insured patients to cover those losses. In contrast, many small rural hospitals cannot cover losses on Medicaid and uninsured patients because the payments from private payers do not generate significant profits or may not even cover the costs of providing services to the privately insured patients.

COST OF DELIVERING SERVICES IN RURAL HOSPITALS AND CLINICS

Low patient volume represents a persistent challenge to the financial viability of rural hospitals. There is a minimum level of cost needed to maintain the staff and equipment required to provide a particular type of service, whether it be an ED, a laboratory, or a primary care clinic. As a result, the average cost per service will be higher at a hospital that has fewer patients. In addition, the hospital will need to incur a minimum level of overhead costs that include accounting and billing, human resources, medical records, information systems, and maintenance. These costs are allocated to each hospital service line, so the fewer services the hospital offers, the higher the cost for each service.[16]

The mix of fixed costs paired with low volumes can result in instances where the current fee-for-service payments are often not large enough to cover the cost of delivering services in small rural communities. For example, a hospital ED must be staffed by at least one physician around the clock regardless of how many patients visit the ED. Generally, a small rural hospital will have fewer ED visits, but the standby capacity cost remains fixed, which means the average cost per visit will be higher. Therefore, a payment per visit that is high enough to cover the average cost per service at a larger hospital will fail to cover the costs of the same services at a smaller rural hospital. Exacerbating this issue is that some private plans pay small rural hospitals less than they pay larger hospitals for delivering the same services even though the cost per service at the rural hospital is intrinsically higher.[17]

Due to the low population density in rural areas, it is impossible for many rural hospitals to have enough patients to use the full minimum capacity of services such as an ED. Medicare explicitly pays small rural hospitals more to compensate for the higher average costs, but most other payers do not, which is why small rural hospitals have greater financial problems.

QUALITY MEASUREMENT CHALLENGES IN RURAL HOSPITALS

Current quality measurement systems are problematic for small rural hospitals. Many commonly used quality measures cannot be used in small rural hospitals because there are too few patients to reliably measure performance, and some measures are not relevant at all for small rural hospitals because they do not deliver the services being measured.[18]

Rural hospital volume varies significantly for several reasons including the population of the community, the age and health status of the population, the availability of other primary care options, and the accessibility of the hospital. Many currently used quality measures are not applicable to numerous types of patients and aspects of care, and many focus on a specific condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size because they do not have enough patients with that specific condition. Moreover, rural hospitals

often face challenges reporting quality measurement data due to limited staff, time, and infrastructure.

The typical value-based payment system of bonuses and penalties often penalizes rural providers and hospitals. Again, the small patient panels inherent in rural care mean that providers can easily be penalized for random variation over which they have no control.[19]

RISK ADJUSTMENT CHALLENGES IN RURAL HOSPITALS

In addition to the reliability problems in measurement caused by small populations, the differences between rural and urban populations with respect to age, health status, and ability to access services makes risk adjustment of quality and spending measures essential. Random variation and outlier patients make risk adjustment scores less accurate at small hospitals than at hospitals with large patient populations.[20] The greater statistical variation at rural hospitals often leads to quality incentive payments going to higher volume hospitals that can achieve lower standard deviations but are not necessarily delivering higher quality care.

Moreover, risk adjustment is based on diagnosis codes recorded on claims forms. Since payments to CAHs do not depend on what diagnoses a patient has, diagnosis codes tend to be underreported by rural hospitals.[21] Also, the use of diagnosis codes can fail to capture risk appropriately including the lack of a comorbid condition diagnosis due to barriers to care such as distance from the health care setting and lack of support services in the community. As a result, rural hospitals and clinics can appear to have healthier patients or worse outcomes than they really do. Risk adjustment can also make spending in rural communities appear higher than it is. For example, MA risk adjustment scores fail to accurately measure the true differences in patient health because the hierarchical condition category coding used in MA payments are retrospective based on past chronic conditions, not acute or new chronic conditions. Therefore, there is no risk adjustment for patients with injuries, acute conditions, or those newly diagnosed with cancer or diabetes, among other conditions. Likewise, the higher barriers for rural patients to obtain preventive care can cause a more severe presentation of diseases once finally diagnosed, requiring higher costs of care and poorer absolute outcomes.

RELEVANT AMA POLICY

The AMA has significant policy on rural health. Policy H-465.994 supports the AMA's continued and intensified efforts to develop and implement proposals for improving rural health care. AMA policy specific to rural hospitals includes Policy H-165.888 stating that any national legislation for health system reform should include sufficient and continuing financial support for rural hospitals. Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach toward certification of small, rural hospitals. Policy H-465.979 recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities. Policy D-465.999 calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; oppose the elimination of the state-designated CAH "necessary provider" designation; and pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

Policy H-385.913 discusses payment and delivery reform in the context of the shift away from volume to value. The policy states that alternative payment models (APMs) must provide flexibility to physicians to deliver the care their patients need. Policy H-385.913 also calls for

APMs to be feasible for physicians in every specialty and for practices of every size to participate in. Importantly, Policy D-385.952 directs the AMA to continue encouraging the development and implementation of APMs that provide services to improve the health of vulnerable and high-risk populations, including those in rural areas.

Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid payments. Policy H-290.976 advocates that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. Policy H-290.997 promotes greater equity in the Medicaid program through adequate payment rates that assure broad access to care. Further, Policy D-290.979 supports state efforts to expand Medicaid eligibility as authorized by the ACA.

DISCUSSION

Long-term solutions are needed to effectively address the health needs of the rural population. Preventing the closure of rural hospitals that provide essential services is a first step. Rural hospitals must be paid adequately to support the costs of delivering essential services, and they should have the flexibility to tailor available services to the needs of their local populations.

To begin accomplishing its goal of providing adequate payment for rural hospital services, the Council recommends reaffirming Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility, and reaffirming Policy H-290.976 stating that Medicaid payments be at least 100 percent of Medicare payment rates. Medicaid eligibility and enrollment are evidence-based factors strengthening the viability of rural hospitals. Medicaid expansion, particularly if it is accompanied by adequate payments, will improve hospital financial performance and sustainability, and lower the likelihood of closure, especially in those rural markets with large numbers of uninsured patients. For example, since 2010, of the eight states with the highest levels of rural hospital closures, none are Medicaid expansion states. A key cause of financial losses at most rural hospitals is the volume of care provided to uninsured patients, so a key component of any strategy for sustaining rural health care services is increasing the number of insured residents.

The Council identified the need for better and more reliable payment for rural hospitals that support their sustainability and recommends that a series of policies be adopted to ensure that payment to rural hospitals is adequate and appropriate. Since small rural hospitals need to sustain essential services even with low volumes of services, the Council recommends that health insurance plans provide such hospitals with a capacity payment to support the minimum fixed costs of essential services, including surge capacity, acknowledging that a small rural hospital requires a baseline of staffing and expenses to remain open regardless of volume. It is also recommended that payers provide adequate service-based payments to cover the costs of services delivered in small communities. The Council also recommends that the capacity payment provide adequate support for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner. Regarding quality measurement, the Council recommends only using quality measures that are relevant for rural hospitals and setting minimum volume thresholds for measures to ensure statistical reliability and avoiding financial penalties that might occur from failing to have met specific quality metrics due to lower volumes. To help effect these changes, the Council recommends encouraging employers and rural residents to choose health plans that adequately and appropriately pay the rural hospitals.

The Council notes that taking these steps to ensure adequate and reliable payment for rural hospitals is critical to addressing the barriers to procedural service lines. A small patient population and declining revenue stifles the ability of rural hospitals to add new service lines that not only attract needed specialists to underserved areas but also aid in the financial sustainability of a rural

hospital. The Council believes that addressing payment issues for rural hospitals will help give those hospitals the flexibility to offer more complex services. In turn, those services will boost financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately increase patient access to care.

The Council also reiterates the need to address payment for primary care services at rural facilities. The Council recommends voluntary monthly payments for primary care providers so that physicians have the flexibility to deliver services in the most effective manner, particularly for those patients for whom travel is a significant barrier to care. Importantly, such monthly payments should include an allowance and expectation that some services would be provided via telehealth or telephone.

Additionally, the Council recommends policy that encourages transparency among rural hospitals regarding their costs and quality outcomes. It will be essential that rural hospitals publicly demonstrate that higher payments are needed to support the cost of delivering high quality care.

The challenges facing the rural health system are varied and complex. Although many steps are needed to ensure access to care and quality outcomes for the rural population, the Council offers these recommendations as a pragmatic step forward to address the needs of rural populations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)

3. That our AMA support that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:

    a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
    b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
    c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
    d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
    e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and
    f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)

4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes. (New HOD Policy)

5. That our AMA support better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital. (New HOD Policy)

6. That our AMA encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(JUN-21)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful exertions, vibrations, mechanical compression, or sustained or awkward positions; and

Whereas, RSI is a known work-related injury which falls under the purview of the Occupational Safety and Health Administration (OSHA); and

Whereas, Most RSI results from cumulative trauma rather than a single event; and

Whereas, Repeated exposure to work-related stressors can result in physician burnout; and

Whereas, Cerebral centers and activity are most certainly within the domain of the nervous system; and

Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI and, as such, should fall under the aegis of OSHA; therefore be it

RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

New York ranked this as vitally important – it has to do with physician health and well-being which has been sorely tested during the last year. Physicians are under enormous stress each and every day, and the COVID pandemic added immeasurably to that stress. The incidence of physician suicide increased during the last year – a clear indication of the added stress of COVID. Working without the necessary and proper equipment during the pandemic and watching colleagues die of COVID while doing their job has all added to the burden of being a physician. Physicians have few protections for their wellbeing and good health. Many feel that physicians should be "super-heroes" unaffected by the stress of providing health care in today's very different environment. Adding physician burnout as an RSI subject to OSHA oversight would go a long way toward ensuring physicians work situation is monitored to ensure that they do not burnout.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(JUN-21)

Introduced by: New York

Subject: Addressing Inflammatory and Untruthful Online Ratings

Referred to: Reference Committee G

Whereas, More than 70 percent of consumers search for health information online, according to Pew Research Center, and 77 percent of consumers say they use online reviews as the first step in finding a new physician*; and

Whereas, Online reviews are an open public forum that allows patients to share their stories and photos regarding their experiences with doctors; and

Whereas, Often these reviews are negative and accuse the doctors of complications or mismanagement of medical visits, treatments and procedures that they have had; and

Whereas, Bad online ratings can wreak havoc on doctors' businesses, in extreme cases driving physicians to leave a state to practice elsewhere; and

Whereas, Ratings sites will take down reviews that use profanity or can be proven fake, but they typically won't edit or remove a review simply because a doctor (or any business) disputes what is in it; and

Whereas, Critics of public airing of patient comments argue that it puts a doctor in an untenable position because federal privacy laws such as HIPAA prohibit doctors from compromising patient confidentiality by responding directly to a patient's complaint, leaving physicians with limited ability to rebut complaints; and

Whereas, Physicians are uniquely vulnerable to public criticism and potential adverse publicity regarding their professional abilities and find this extremely unfair and unjust; and

Whereas, Change.org (a petition website operated by for-profit Change.org, Inc., which hosts sponsored campaigns for organizations and serves to facilitate petitions by the general public) has posted a petition signed by over 42,000 physicians calling for an immediate end to online reviews of ALL doctors and providers who are subject to HIPAA and medical privacy laws, stating further that reviews should not be posted until physicians can defend themselves or respond; and

Whereas, The problem of addressing unfair online reviews is faced by physicians throughout the country transcending regions and states; therefore be it

RESOLVED, That our American Medical Association take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/23/21

* 2015 survey of 1,438 patients by Software Advice, a software research and advisory firm.

AUTHOR'S STATEMENT OF PRIORITY

The issue of inaccurate and defamatory information posted on the internet, social media and other post sites has been heavily discussed by media during the last year. The damage that those posts and reviews can do has been made abundantly clear – causing some on the receiving end to go so far as suicide. It is clear that negative reviews which may be unfounded and which physicians are given no opportunity to refute can cause lasting damage, not only to a physician's practice and livelihood but to his/her mental health. The potential for patient harm exists as well, since some patients may believe erroneous information, doing damage to their own health care. Social media outlets may be reluctant to remove negative posts, but online review organizations should be held to a higher standard. AMA has policy but it is six years old and does not specify the right to due process. It requires action so that physicians are given the rights and due process everyone deserves. This is in many ways an issue of patient and physician well-being and should not be ignored during these especially stressful times.

RELEVANT AMA POLICY:

Anonymous Cyberspace Evaluations of Physicians D-478.980
Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.
Citation: (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(JUN-21)

Introduced by: New York

Subject: Employed Physician Contracts

Referred to: Reference Committee G

Whereas, Employed physician contracts contain clauses to the effect that the physician maintains privileges ONLY if the physician remains employed by the hospital/health system; and

Whereas, An employed physician due to circumstances beyond the physician's control could be dismissed and upon that dismissal, lose all privileges despite having been credentialed according to hospital/health system bylaws; and

Whereas, Hospital medical staff bylaws ensure rights and due process for all members of the medical staff; therefore be it

RESOLVED, That our American Medical Association advocate in support of all employed physicians receiving all rights and due process protections afforded all other members of the medical staff. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution is a High priority for all employed physicians, which many have found are actually the majority of US physicians.

While the Independent Medical Staff physicians' hospital privileges are protected by due process enshrined in their by-laws, employed physicians hospital privileges remain in effect ONLY as long as they remain in their employment. This means that should the physician be dismissed, that means that that physician's privileges are no longer in effect, since the usual due process afforded by the staff by-laws are superseded by the employment contract. For example, a physician who complained "too much" about the lack of appropriate PPE during the pandemic could not only lose his/her job but would have to begin at square one should that physician wish to regain privileges – those bylaws would no longer be in effect.

It has been suggested by other delegates to the AMA HOD, that not only was this resolution extremely important, but it did not go far enough. The phrase "seek regulation/legislation" was suggested as an addition to ensure that all employed physicians retain the same rights and process afforded the members of the hospital medical staff within their bylaws.

RELEVANT AMA POLICY

Fair Process for Employed Physicians H-435.942
1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.
2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.
Citation: Res. 007, I-16

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b) Physicians should never be coerced into employment with hospitals, health care systems, medical

groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.
Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c) Employed physicians who are members of the organized medical staff should be free to exercise

their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.
Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

Physician and Medical Staff Member Bill of Rights H-225.942
Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:
Preamble
The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.
The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.
Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.
From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:
I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body.
b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.
II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staffs ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's

operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organizations governing body.
f. The right to engage the health care organizations administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each members ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(JUN-21)

Introduced by: Oklahoma

Subject: Eliminating Claims Data for Measuring Physician and Hospital Quality

Referred to: Reference Committee G

Whereas, The US Centers for Medicare and Medicaid Services (CMS) has been publishing mortality data of hospitalized patients since 2008; and

Whereas, Public reporting has been expanded to cover multiple quality measures by many entities over the past few years; and

Whereas, The debate rages over whether to focus on outcomes versus care processes when assessing quality; and

Whereas, The validity of outcomes measures is under scrutiny when the data used for reporting purposes is claims data; and

Whereas, Any models that are used for assessing quality should be reliable and valid; and

Whereas, Models using data on severity of illness consistently outperform models using only comorbidity data; and

Whereas, Factors associated with severity of illness are the strongest predictors of quality; and

Whereas, Data from hospital billing systems contain no factors associated with the severity of illness; and

Whereas, Because of the variability of information in the medical record, claims data cannot reliably code comorbid conditions; and

Whereas, It is time to eliminate measures based on claims data from public reporting and other programs designed to hold physicians and hospitals accountable for improving outcomes; therefore be it

RESOLVED, That our American Medical Association collaborate with the US Centers for Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)

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

Received: 05/05/21

AUTHORS STATEMENT OF PRIORITY

Thank you for your consideration of the prioritization matrix for Eliminating Claims Data for Measuring Physician and Hospital Quality. Currently, physicians are being graded and assessed on claims data; however, claims data has no place in the assessment of quality of care delivery. Coders typically generate claims data. Measuring and ranking physicians on claims data says little about the quality of the care delivered. CMS and other stakeholders should replace the use of claims data with outcomes measures in determining the quality of care delivery. This matter is urgent as claims data is currently utilized in determining physician reimbursement. In the deleterious economic climate of the COVID-19 pandemic, revenue stream sustainability is of high importance, especially to economically vulnerable rural practices. This issue is timely and is affecting all physicians nationwide. We feel our AMA is most appropriate entity to tackle this issue and will have a positive impact.

Reference:
https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2757527?resultClick=1

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(JUN-21)

Introduced by: Arizona, Colorado

Subject: Improving the Prior Authorization Process

Referred to: Reference Committee G

Whereas, Prior authorization is a recognized factor in the delay of patient care; and

Whereas, Each insurance company, pharmacy benefit manager and retail pharmacy all have different prior authorization processes which create undue stress and time to complete these processes on physician practices; and

Whereas, Denials from insurance companies, pharmacy benefit managers, and retail pharmacies do not inform the prescribing physician at the time of the denial of alternative but similar medications which are on the patients formulary; therefore be it

RESOLVED, That our American Medical Association promote that all medication denials from insurance companies, pharmacy benefit managers or retail pharmacies provide the approved formulary alternatives in the same class of medications or the step edit requirements at the time of the denial to the prescribing physician (Directive to Take Action); and be it further

RESOLVED, That at the time of denial by insurance companies, pharmacy benefit managers, or retail pharmacies, that our AMA advocate they be required to inform the patient of the lowest cash or discount card price for that medication. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

The resolution is timely and should be discussed at the A2021 for the following reasons:

1. Physician burnout, which is at an all-time high during the Covid-19 pandemic, is due in part by the increasingly onerous prior authorization process. The resolution is an attempt to simplify the process for physician practices by forcing the denying pharmacy benefit manager, insurance company, or retail pharmacy to immediately at the time of medication denial to provide the prescriber with formulary alternatives and not force the provider to submit a prior authorization to determine the alternative medications which are on the formulary.

2. Patients deserve to know at the time of purchase of medications that the cash or discount cash price may be lower than the copay required by their insurance. If a medication is denied by insurance, the patient should be provided the cash or discount card price so they may determine if their purchase should not be subject to further insurance company delay due to the prior authorization process.

3. The resolution demands transparency in the prior authorization process to both the patient and physician which is not currently the case. Further delay in consideration of the resolution will cost patients dollars and practices in time and money they both can ill afford.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(JUN-21)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Prevent Medicare Advantage Plans from Limiting Care

Referred to: Reference Committee G

Whereas, There are Medicare guidelines for most treatments for patients including, but not limited to criteria for admissions, diagnostic testing, medications, and procedures; and

Whereas, Medicare Advantage plans may not consistently follow Medicare guidelines resulting in patients who are insured by Medicare Advantage plans not receiving the same level of treatment as patients insured by standard Medicare; and

Whereas, When asked about denial of services, the Medicare Advantage plans state that Medicare guidelines allow them to approve a service but do not require them to do so; and

Whereas, Medicare Advantage plans often use proprietary criteria (such as Milliman and InterQual) or NaviHealth algorithms to determine eligibility of Medicare beneficiaries for admissions, diagnostic testing, medications, and procedures, which is an additional barrier that limits access to services and is often at odds with the professional judgement of the patient's physician; and

Whereas, Patients who have symptoms consistent with Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID") could be denied necessary treatment by the use of proprietary criteria; therefore be it

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that Medicare guidelines are followed for all Medicare patients and that care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate against applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions when the criteria are at odds with the professional judgment of the patient's physician. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

We believe that this resolution should be included for the June 2021 Special Meeting of the AMA HOD because there are ongoing access to care issues for many Medicare patients who are in high risk categories for poor health outcomes due to the COVID-19 pandemic and those suffering from Long COVID. This affects all physicians who care for Medicare patients. Ensuring equal access to care for all those covered by Medicare and Medicare Advantage (MA) plans is timely and imperative, because all patients deserve equal access to medically necessary care. MA and other private plans account for 40 percent of all Medicare beneficiaries. Other private plans consist of private fee-for-service plans, cost plans, Medicare medical savings account plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid plans participating in CMS's financial alignment demonstration. MA enrollment represents 39 percent of all 62.2 million Medicare beneficiaries (and 42 percent of all 56.5 million beneficiaries enrolled in both Medicare Part A and Part B). Enrollment in MA plans that are paid on an at-risk capitated basis reached 24.0 million enrollees in February 2020. The most recent data for 2021 indicated there was a 13% increase in MA plans compared to 2020, which equates to 3,550 total MA plans[1].

[1] Biniek, J., Freed, M., Damico, A. and Neuman, T., 2020. *Medicare Advantage 2021 Spotlight: First Look*. [online] KFF. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/ [Accessed 11 May 2021].

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(JUN-21)

Introduced by: American College of Rheumatology, American Gastroenterological Association, American Academy of Ophthalmology, American College of Gastroenterology, American Academy of Dermatology, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology

Subject: Financial Incentives for Patients to Switch Treatments

Referred to: Reference Committee G

Whereas, All patients should have access to the medications they and their provider feel are most appropriate; and

Whereas, Biologic drugs are highly effective and have the potential to reduce long-term disability; however, they are not without certain risks. All classes of biologics used in autoimmune diseases may cause serious adverse events. The decision to choose one biologic over another requires careful clinical evaluation and consideration by a physician and patient. Factors such as an individual patient's age, gender, diagnosis, medications, specific organ manifestations, antibody status, disease severity, comorbid conditions, and ability to tolerate the route of administration strongly influence the specific biologic choice; and

Whereas, Due to these highly individual characteristics among patients, the journey to finding an effective treatment is often long and challenging. The complex medical decision making, and subsequent risks associated with these medications, fall on the physician and the patient, so these decisions should not be curtailed by a health plan's coverage policies; and

Whereas, In March of 2021, Cigna notified patients that they could be eligible for a $500 pre-paid medical debit card if they agree to stop taking Cosentyx (secukinumab) and switch to a payer-preferred alternative medication; and

Whereas, Incentivizing patients who are stable on an effective therapy to abandon treatment for non-medical reasons needlessly puts them at risk for significant long-term consequences including irreversible damage and disability. Patients who are switched to another treatment may experience serious disease flares, as even drugs with similar mechanisms of action have widely variable patient to patient effectiveness; and

Whereas, Using money to persuade patients to make a choice against their own health raises ethical concerns and is highly irresponsible, especially when so many have suffered financially due to the ongoing pandemic and may be swayed by financial incentive to make a decision contrary to their health interests; and

Whereas, This initiative jeopardizes patients' health, interferes with medical decision making, and undermines the doctor-patient relationship by possibly obliging physicians to counsel patients to forgo the $500 payment in order to safeguard their health; and

Whereas, This program will disproportionately affect patients of lower socio-economic status, who may have less ability to refuse such a payment despite their health interests; and

Whereas, Other large national insurers are contemplating adopting or expanding similar policies financially incentivizing patients to switch treatments, and these policies could quickly become common across multiple disease states if not checked; and

Whereas, It is of the highest urgency during this time of economic uncertainty and public health emergency that payers avoid policies that would take advantage of financial instability and jeopardize patient health; therefore be it

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing financial incentives for patients to switch treatments (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would ban insurer policies that provide patients financial incentives to switch treatments, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with state regulators urging review of the legality of such policies providing financial incentives to patients who switch to preferred drugs. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Especially during the PHE, ensuring patients stay on their medication is urgent and of the highest priority. However, new tactics by insurance companies to financially incentivize patients who are stable on effective therapy to abandon that treatment for non-medical reasons needlessly put patients at risk.

This year, Cigna notified patients they could receive $500 debit cards if they agreed to stop taking a non-preferred medication and switch to the payer-preferred alternative. There are indications this policy is planned to be expanded and other large payers including UHC have signaled desires to adopt or expand this type of program. Additionally, at least one piece of state legislation proposed this year would explicitly make these policies legal. Without action in opposition these tactics are likely to proliferate, affecting many physicians and patients.

Payer policies should not interfere with complex medical decisions about treatments. Using monetary incentives to persuade patients to make choices against their own health is particularly irresponsible when so many have suffered financially due to the COVID-19 pandemic, especially patients of lower socio-economic status who may have less ability to refuse a payment despite health interests.

It is of the highest priority during this time of economic uncertainty and public health emergency that payers do not take advantage of financial instability and jeopardize patient health. It is urgent that we have policy in opposition and take action protecting patients' health, medical decision making, and the physician-patient relationship.

RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920
1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.

5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.
CMS Rep. 2, I-19

E-9.6.3 Incentives to Patients for Referrals
Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice.
Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.
AMA Principles of Medical Ethics: I,II,VIII

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(JUN-21)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee G

Whereas, Medicare Advantage rules for plans do not stipulate how record requests are handled, nor any limits to number or repetitiveness of these requests; and

Whereas, Complying with these records requests can require extensive staff time and other associated costs; and

Whereas, Practices are not reimbursed by Medicare Advantage companies for the staff time involved in complying with these requests; and

Whereas, Each Medicare Advantage plan has different rules for record requests governed by the contract between the plan and provider; therefore be it

RESOLVED, That our American Medical Association advocate for the relevant agencies and stakeholders to prevent Medicare Advantage plans from requesting records from practices solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise advocate that the plan will reimburse the practices for their efforts in obtaining additional requested information. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The COVID-19 pandemic has created substantial financial issues for physician practices due to reductions in elective procedures and challenges maintaining appropriate staffing. Requests from Medicare Advantage plans for medical records have been a consistent issue that requires extensive staff time and may be costly for the practice to complete. Limiting these requests will help already stressed practices as they recover after the pandemic subsides. Finding solutions to the financial pressures facing practices right now cannot wait if the health care system in the United States is to adequately recover from the pandemic. The AMA's current policy does not include a specific maximum amount of records that plans should be authorized to request. Due to the national nature of Medicare Advantage plans, the AMA is in the best position to advocate for these changes and advocating for the relief of administrative burdens is an important component of promoting the art and science of medicine.

RELEVANT AMA POLICY

Limiting Access to Medical Records H-315.987
Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.
Citation: Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 06, A-16

Informational Reports

BOT Report(s)

02 2020 Grants and Donations
04 Update on Corporate Relationships
05 AMA Performance, Activities and Status in 2020
06 Annual Update on Activities and Progress in Tobacco Control: March 2020 Through February 2021
08 Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report)
11 Redefining the AMA's Position on ACA and Healthcare Reform

CEJA Opinion(s)

01* Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients
02* Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians"

CEJA Report(s)

04* Augmented Intelligence & the Ethics of Innovation in Medicine
05* Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

CLRPD Report(s)

01* Demographic Characteristics of the House of Delegates and AMA Leadership

Report of the Speakers

01 Recommendations for Policy Reconciliation

** Contained in the Handbook Addendum*

REPORT OF THE BOARD TRUSTEES

B of T Report 02-JUN-2021

Subject: 2020 Grants and Donations

Presented by: Russ Kridel, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2020.

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American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2020
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through RAND Corporation)	Health Insurance Expansion and Physician Distribution	$ 29
Centers for Disease Control and Prevention (subcontracted through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	257
Centers for Disease Control and Prevention (subcontracted through National Association of Community Health Centers, Inc.)	Preventing Heart Attacks and Strokes in Primary Care	348
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	163
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	9
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	44
Government Funding		**850**
American Heart Association, Inc.	Release the Pressure Program	200
American Heart Association, Inc.	Target: Blood Pressure Initiative	52
American Medical Association Foundation via contributions from Genentech, Inc.	Accelerating Change in Medical Education Conference	45
American Medical Association Foundation via contributions from Pfizer, Inc.	Accelerating Change in Medical Education Conference	23
Physicians for a Healthy California	Graduate Medical Education Innovations Summit	15
Nonprofit Contributors		**335**
Total Grants and Donations		**$ 1,185**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-JUN-2021

Subject: Update on Corporate Relationships

Presented by: Russ Kridel, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2020. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for American Medical Association corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2020 RESULTS

In 2020, 64 new activities were considered and approved through the Corporate Review process. Of the 64 projects recommended for approval, 31 were conferences or events, nine were educational content or grants, 20 were collaborations or affiliations, two were member programs, one was an American Medical Association Foundation (AMAF) program and one was an AMA Innovations, Inc. program (Appendix B).

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

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Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity, and Health and Science.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.

- AMA sponsorship of external events.

- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)

- Member programs such as new affinity or insurance programs and member benefits.

- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.

- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.

- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2020

Project No.	Project Description	Corporations	Approval Date
CONFERENCES/EVENTS			
4648	**Poynter Institute Webinar –** Sponsorship with AMA name and logo.	Poynter Institute	12/1/2020
4694	**National Press Club Webinar –** COVID-19 vaccine focused webinar sponsorship with AMA name and logo.	National Press Club	12/2/2020
4907	**American Bar Association (ABA) Opioid Summit –** Sponsorship with AMA name and logo.	American Bar Association (ABA)	12/16/2020
27981	**Alliance for Health Policy Post Election Symposium –** Updated virtual sponsorship with AMA name and logo.	Alliance for Health Policy	10/5/2020
35268	**AMA/American Health Information Management Association (AHIMA) Outpatient Clinical Documentation Improvement (CDI) Workshop –** Co-branding event with AMA name and logo.	American Health Information Management Association (AHIMA)	8/31/2020
36280	**2021 National Rx Drug Abuse & Heroin Summit Update –** Repeat support of event with AMA name and logo.	University of Kentucky, Northern Kentucky University Deterra Drug Deactivation System	10/7/2020
37286	**Women Business Leaders Annual Sponsorship 2020 –** Sponsorship with AMA name and logo.	Women Business Leaders (WBL) Amgen, Inc. McKesson Corporation MCG (Milliman Care Guidelines) Hearst Health Tivity Health	6/16/2020
37366	**National Lesbian and Gay Journalist Association –** Convention sponsorship with AMA name and logo.	National Lesbian and Gay Journalist Association (NLGJA)	2/4/2020

37455	**Bellin Health Team-Based Care Training Camp –** Sponsorship with AMA name and logo.	Bellin Health Systems	2/14/2020
37486	**HCA Healthcare Event Collaboration –** Updated collaboration with HCA for residents with AMA name and logo use.	HCA (Hospital Corporation of America) Healthcare	2/19/2020
37467	**Erie Neighborhood House 150th Anniversary Dinner Celebrating Inclusion –** Sponsorship with AMA name and logo.	Erie Neighborhood House	2/14/2020
37487	**Fenway Institute's Conference on Minority Health –** Sponsorship with AMA name and logo.	Fenway Health Harvard Medical Massachusetts Medical Society's LGBTQ Issues Committee	2/19/2020
37515	**HIMSS Health 2.0 Kingdom of Saudi Arabia Conference and Exhibition 2020 Sponsorship –** Sponsorship with AMA name and logo for Health Solutions products.	Healthcare Information and Management Systems Society, Inc. (HIMSS) Adaptive Tech Soft Epic Systems Inter Systems NOMD Holding Company Oasis Vocera Communications Ideal Middle East Sapphire Health Management System (HMS) Elsevier	2/24/2020
37561	**National Association of Black Journalist 2020 Convention –** Sponsorship with AMA name and logo.	National Association of Black Journalists (NABJ) National Association of Hispanic Journalists (NAHJ)	3/4/2020
37597	**2020 Joy in Medicine CEO Consortium Summit –** Sponsorship with AMA name and logo.	Stanford University School of Medicine ChristianaCare	3/13/2020
37686	**Howard Brown Health - Midwest LGBTQ Health Symposium 2020 and Webinar –** Sponsorship with AMA name and logo.	Howard Brown Health ConsejoSano	6/15/2020

37980	**NAMSS Town Hall Webinar Sponsorship** – Repeat sponsorship with AMA name and logo use.	National Association of Medical Staff Services (NAMSS)	4/22/2020
38013	**National Medical Fellowships' Champions of Health Awards 2020 –** Sponsorship with AMA name and logo.	National Medical Fellowships (NMF)	4/29/2020
38181	**AHIP Online Institute and Expo Sponsorship –** Repeat sponsorship with AMA name and logo use.	America's Health Insurance Plans (AHIP) 3M (formerly Minnesota Mining and Manufacturing Company) Accenture Amwell (American Well)	5/29/2020
38245	**American Telemedicine Association 2020 Sponsorship –** Sponsorship with AMA name and logo for annual conference of telehealth providers.	American Telemedicine Association (ATA) Bayesian Health Amwell (American Well) Ziegler InTouch Health	6/9/2020
38299	**Rush University Medical Center - 2020 Virtual West Side Walk for Wellness –** Repeat sponsorship with AMA name and logo.	Rush University Medical Center (RUMC)	6/23/2020
38379	**Structural Racism in Health Professions Education: Curriculum, Structural Competency, and Institutional Change –** AMA name and logo use for webinar collaboration.	Beyond Flexner Alliance (BFA)	7/10/2020
38468	**American Academy of Professional Coders Healthcon Regional Conference 2020 –** Sponsorship with AMA name and logo.	American Academy of Professional Coders (AAPC)	7/28/2020
38536	**Women Leaders in Healthcare Conference –** Sponsorship with AMA name and logo of virtual booth and program.	Modern Healthcare Furst Group NuBrick Partners Keck Medicine of USC (University of Southern California) TeamHealth HARTZ Search GetixHealth University of Alabama at Birmingham (UAB)	7/31/2020

38783	**Rock Health Summit –** Repeat sponsorship with AMA name and logo of digital health conference.	Rock Health Vynyl Accenture Fenwick & West LLP J.P. (John Pierpont) Morgan Chase & Co.	9/9/2020
38819	**NAMSS 44th Educational Virtual Conference & Exhibition –** Repeat sponsorship with AMA name and logo.	National Association Medical Staff Services (NAMSS) SkillSurvey Verity Stream MD-Staff (Applied Statistics & Management, Inc.) Verge Health	9/15/2020
38853	**AHIMA 2020 Conference and Assembly on Education –** Repeat sponsorship with AMA name and logo.	American Health Information Management Association (AHIMA)	9/30/2020
39137	**AHIP Consumer Experience and Digital Health Forum Sponsorship** – Sponsorship with AMA name and logo.	America's Health Insurance Plans (AHIP) 3M (formerly Minnesota Mining and Manufacturing Company) Accenture Amwell (previously known as American Well)	11/6/2020
	Managing Your Health and Wellness in the Era of COVID-19 – AMA name and logo use at World Health Day.	Livongo Health Inc. HLTH, LLC American Diabetes Association (ADA) American Heart Association (AHA)	4/7/2020
	Healthcare Administration Alliance's (HAA) Conference – AMA's Health Solutions participation with name and logo use.	Healthcare Administration Alliance (HAA)	9/15/2020
	Consumer Privacy Framework for Health Data – Framework and webinar with AMA name and logo association with these organizations.	eHI (Enable Healthcare, Inc.) Center for Democracy Technology (CDT) Robert Wood Johnson Foundation 23andMe American College of Physicians Ancestry AI Now Institute American Cancer Society American Hospital Association Ascension Change Healthcare Children's National Hospital Ciitizen Corporation CVS (Consumer Value Stores) Health	8/25/2020

		Datavant Electronic Frontier Foundation Elektra Labs Evidation Fitbit, Inc. Future of Privacy Forum Georgetown Institute for Technology Law and Policy Google LLC GW (George Washington University) School of Medicine Hispanic Technology and Telecom Partnership Hogan Lovells Marshfield Clinic Health System Microsoft National Partnership for Women & Families New America's Open Technology Institute Pew Charitable Trusts Salesforce Teladoc Health Under Armour University of Nebraska Governance and Technology Center Waldo Law Offices Wellmark Blue Cross and Blue Shield Yale University	

EDUCATIONAL CONTENT OR GRANTS

36512	**Collaboration with LuCa (Lung Cancer) National Training Network –** The Education Center to host "Lung Cancer and the Primary Care Provider" educational module. AMA name and logo use on program materials.	LuCa (Lung Cancer) National Training Network University of Louisville School of Medicine Bristol-Myers Squibb (BMS) Foundation Cancer Care™ Initiative	1/27/2020
37287	**AMA Mini Z Well-Being Survey –** Technology solution survey with AMA name and logo.	Hennepin Healthcare System, Inc. Hennepin County Medical Center (HCMC)	1/23/2020
37566	**Edge-U-Cate Credentialing School/Certification Study Program –** Sponsorship with AMA name and logo.	Edge-U-Cate LLC ABMS Solutions/Certi-FACTS American Osteopathic Information Association (AOIA) Elsevier	3/3/2020

37718	**Center for Health Equity Curriculum and Content Development with Health Begins –** A content development agreement with AMA name and logo.	HealthBegins, LLC	3/20/2020
37973	**MAVEN Project including Volunteers in Medicine for COVID-19 Emergency Workforce Augmentation** – This guide includes resources to aid health care workforce volunteer process around credential verification.	MAVEN (Medical Alumni Volunteer Expert Network) Project Volunteers in Medicine (VIM)	4/21/2020
38479	**Collaboration with Alzheimer's Association –** AMA name and logo use to announce collaboration for free online educational modules.	Alzheimer's Association (AA) MetLife Foundation	7/28/2020
38582	**CPT® E/M 2021 – Content Development Initiative –** Collaboration to develop educational content with AMA name and logo for branding.	Nordic Consulting Partners, Inc.	8/12/2020
38583	**Collaboration with Stanford Center for Continuing Medical Education** – Hosting set of free online educational modules with AMA name and logo.	Stanford University Stanford Center for Continuing Medical Education Pfizer, Inc.	9/24/2020
	Morehouse School of Medicine Book Quote – AMA Board member quote for "The Morehouse Model – How one school of medicine revolutionized community medicine and health equity" book.	Morehouse School of Medicine ACE (Adverse Childhood Experiences) Consortium	2/10/2020

COLLABORATIONS/AFFILIATIONS

4753	**Cardz for Kidz Sponsorship 2020 –** Repeat sponsorship with AMA name and logo for program supporting hospitalized and traumatized children.	Cardz for Kidz!	12/18/2020

4929	**Manatt Health –** National policy roadmap focused on the nation's drug overdose epidemic with AMA name and logo.	Manatt Health	12/15/2020
4958	**Ad Council –** National communications initiative with use of AMA name and logo, to educate the public and increase the use of the COVID-19 vaccines.	Ad Council (The Advertising Council, Inc.)	12/18/2020
5501	**COVID Collaborative –** Bipartisan coalition with AMA name and logo, focused on the effective response to COVID-19.	COVID Collaborative	12/23/2020
36397	**HL7 Benefactor Membership –** Renewal of membership with AMA name and logo.	Health Level Seven International (HL7)	2/4/2020
37393	**ESSENCE Campaign to Promote Heart Health –** Sponsorship with AMA name and logo in first quarter. Addition of Minority Health Institute (MHI) and WW International Inc. in fourth quarter.	ESSENCE Communications Inc. American Heart Association (AHA) National Medical Association (NMA) Association of Black Cardiologists, Inc., (ABC) Minority Health Institute (MHI) WW International Inc. (formerly Weight Watchers)	10/13/2020
37569	**Physician Innovation Network (PIN) and Telehealth Implementation Playbook Collaborators –** AMA Physician Innovation Network (PIN) and Telehealth Implementation Playbook collaboration agreements with limited AMA name and logo use.	MD++ R&T IMG Health In Her Hue The Rounds IEEE/EMBS (Engineering in Medicine and Biology Society) National Digital Inclusion Alliance (NDIA) Cambia Grove Xealth Medici OhMD, Inc. University of Louisville Texas Medical Association The Physicians Foundation Creekside Endocrine Associates	8/25/2020
38007	**Research Project for High-Performing Physician-Owned Private Practices** – Collaboration with AMA name and logo used in final report.	Mathematica	4/28/2020

38040	**COVID-19 Healthcare Coalition –** Organizational membership and participation in telehealth workgroup and study with AMA name and logo.	COVID-19 Healthcare Coalition	5/4/2020
38168	**Hilton COVID Resident Relocation Support –** Discounted extended Hilton hotel stay rates for residents featured in the COVID resource guides.	Hilton Worldwide Holdings Inc.	6/2/2020
38169	**MAP (Measure, Act, Partner) Dashboards for Health Care Organization (HCO) –** The AMA MAP BP™ Dashboard is an evidence-based quality improvement (QI) program providing sustained improvements in blood pressure (BP) control through monthly reports, tracking data and outcome metrics.	Tandem Health (South Carolina)	12/7/2020
38433	**COVID-19 Writer's Project –** The COVID-19 Writers Project captures a viewpoint from inside a virus's hotspot examining health outcomes that are impacted by socio-economics, education and race. Acknowledgement of AMA's participation with name and logo use.	Brooklyn Community Foundation Pulitzer Center National Geographic BK (Brooklyn) Reader The Original Media Group, LLC	7/18/2020
38662	**ASHP Pharmacogenomics Collaboration on Precision Medicine –** Co-branding with AMA name and logo for jointly developed programming and content.	American Society of Health-System Pharmacists (ASHP)	8/28/2020
38663	**SNOMED Virtual Clinical Terms (CT) Expo 2020 and CPT/SNOMED Demonstration Tool –** Sponsorship with AMA name and logo.	SNOMED International SNOMED CT (Clinical Terms) 3M (formerly Minnesota Mining and Manufacturing Company) Clinical Architecture Goldblatt Systems Vidal Group West Coast Informatics	8/31/2020

38777	**Improving Health Outcomes (IHO) Self-Measured Blood Pressure (SMBP) Monitoring Pilot** – Pilot test for a digital health and remote patient monitoring solution. AMA name and logo on pilot presentations.	MEDITECH (Medical Information Technology, Incorporated) Berkshire Health Systems	10/14/2020
39040	**Medical Alley Webinar Series Sponsorship –** AMA name and logo association with Minnesota based medical technology community.	Medical Alley Association	10/16/2020
39080	**Improving Health Outcomes (IHO) Prevention Strategy Collaboration with Health Care Organizations (HCOs) 2020 –** AMA name and logo use alongside these HCOs for prevention of cardiovascular disease and diabetes.	Aledade - Ashley Clinic, KS, Family Care Center, KS, Anne Arundel Medical Center, MD Cone Health Connected Care, LLC, NC University of Mississippi Medical Center, MS Esperanza Health Centers, IL Loyola University Medical Center, IL University of Illinois at Chicago, Department of Medical Education College of Medicine, IL University of North Dakota, NC Mercy, MO Tandem Health, SC Intermountain Healthcare	11/25/2020
39096	**Health Equity & Advocacy Leadership Fellowship –** Fellowship program collaboration with AMA name and logo.	Morehouse School of Medicine (MSM)	10/27/2020
39541	**Women's Wellness through Equity and Leadership Project (WEL 2.0**) – Collaboration with AMA name and logo.	American Academy of Pediatrics American Academy of Family Physicians American College of Obstetricians and Gynecologists American College of Physicians American Hospital Association American Medical Association American Medical Women's Association American Psychiatric Association National Hispanic Medical Association National Medical Association Physicians Foundation	11/24/2020

	Educational Collaboration with Minority Health Institute / Association of American Medical Colleges – Educational venture with AMA name and logo use.	Association of American Medical Colleges (AAMC) The Minority Health Institute (MHI)	9/3/2020

MEMBER PROGRAMS

37632	**Medical Student Outreach Program (MSOP) 2020 Student Incentives –** Membership marketing with AMA name and logo.	Elsevier McGraw-Hill Education Picmonic, Inc SketchyGroup, LLC Ryan Medical Education LLC	3/25/2020
38316	**AMA Participation in Project N95 Program –** AMA collaboration with Project N95, a not-for-profit Personal Protective Equipment (PPE) clearinghouse, to provide AMA members with access to order quality-certified PPE.	Project N95 American College of Physicians (ACP) American Academy of Family Physicians (AAFP) American College of Emergency Physicians (ACEP) Medical Group Management Association (MGMA) American Medical Group Association (AMGA) American Hospital Association (AHA)	6/29/2020

AMA FOUNDATION

	American Medical Association Foundation (AMAF) Corporate Donors 2020 – Corporate donors for 2020.	AbbVie, Inc. Amgen, Inc. Bristol-Myers Squibb (BMS) Eli Lilly and Company Esperion Therapeutics Genentech, Inc. GlaxoSmithKline Merck & Co., Inc. Novartis International AG Pfizer, Inc. Pharmaceutical Research and Manufacturers of America (PhRMA) Sanofi S.A.	11/20/2020

AMA INNOVATIONS INC.

39438	**AMA Innovations Inc. & Onyx Technology –** Collaboration to pursue the ACL's Social Care Referrals Challenge grant and associated promotion.	Onyx Technology LLC NewWave Telecom & Technologies	11/30/2020

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-JUN-21

Subject: AMA Performance, Activities, and Status in 2020

Presented by: Russ Kridel, MD, Chair

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extends across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA is uniquely positioned to deliver results-focused initiatives that enable physicians to answer a national imperative to measurably improve the health of the nation.

Representing physicians with a unified voice

AMA worked closely with the White House, Congress, state lawmakers and a range of federal and state agencies to ease the public health and economic consequences of COVID-19. We secured nearly $180 billion in emergency funding for physician practices and health systems to help recover from the financial devastation of COVID-19 and continue to provide critical care to patients.

AMA pushed the federal government to accelerate production of life-saving PPE for physicians and frontline workers, improve and expand testing capabilities, and revise guidelines for serological and antibody testing.

AMA worked in federal court to protect international medical graduates, as well as physicians and medical students with Deferred Action for Childhood Arrivals – or DACA -- status. AMA joined 32 other leading health organizations in filing a successful amicus brief to ensure the U.S. Supreme Court upheld the DACA program that has richly benefitted the medical community. AMA now serves as a plaintiff in three federal cases, including one that the U.S. Supreme Court has agreed to review next fall involving the Title X program. In addition, AMA has filed friend of the court briefs in state and federal courts around the country on a wide range of critical issues, from LGBTQ health to tort reform, unfair insurer practices to physician free speech rights, tobacco control to patient access to care, with more than 80 briefs filed in 2020 alone.

Throughout the pandemic, the AMA COVID-19 Resource Center was a trusted source of clear, evidence-based guidance throughout the year. Features included daily video updates, action plans, quick-start telehealth guides, care for caregivers and more.

AMA launched a physician-focused webinar series with federal health officials that explored the COVID-19 vaccine development process and rollout. We also launched a comprehensive campaign

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across multiple platforms and channels to build confidence in the safety and efficacy of the new vaccines among physicians, other health care professionals and patients.

AMA supported the year-end omnibus package which avoided major Medicare cuts for most CPT codes, deferred reinstatement of the Medicare sequester, and secured major modifications in surprise billing legislation that originally would have allowed insurers to avoid responsibility to have meaningful networks.

AMA's communications strategy achieved a record 115 billion media impressions in 2020, through nearly 80,000 stories which included 115 national TV interviews and generated $1.1 billion in estimated advertising value equivalent for the AMA.

Removing obstacles that interfere with patient care

AMA worked with the Centers for Medicare & Medicaid Services to reduce physician documentation relating to Evaluation and Management reporting requirements, the first such overhaul of E/M codes in more than 25 years.

AMA continued to work at the state and national levels to push for important prior authorization and step therapy reforms across the U.S., keeping the focus on reducing the volume of prior authorization requirements and its impact on patients care.

AMA introduced a new Coping with COVID-19 for Caregivers assessment survey to help organizations measure and address the unique demands of the pandemic on their staffs. In 2020, over 80 health care systems from 30 states deployed the assessment resulting in more than 50,000 individual responses. The data findings were compiled into a national COVID-19 comparison report for organizations to compare their survey results to national benchmarks. AMA compiled a guide with practical strategies for health system leadership to consider in support of their physicians and care teams and conducted a COVID-19 Roundtable for shared learning among health system leaders.

AMA's STEPS Forward™ portfolio expanded with 12 new and 19 updated toolkits, educational modules, videos, podcasts customizable resources to help physicians and their teams streamline their workflows for improved patient care.

AMA developed a checklist that provided physicians and administrators with guidance and strategies on controlling labor costs and information about stimulus relief considerations and legal compliance during the pandemic.

AMA's guide to Creating a Resilient Organization offered 17 steps to caring for health care workers before, during and after COVID-19, providing practical tips on coping during times of acute stress, lowering the incidence of chronic stress illness and injury.

Supporting physicians' mental health needs, AMA launched a Behavioral Health Integration Collaborative in partnership with leading medical societies to provide practical steps to blend medical and behavioral health services with primary care.

Leading the charge to confront public health crises

AMA's Center for Health Equity helped lead a national conversation about the pandemic's disproportionate impact on communities of color, the importance of accurate, nationwide data

collection, and advanced policies that decrease inequities, supported equitable access to care and research, and improve culturally competent care.

AMA responded to dire shortages of personal protective equipment by helping secure hundreds of thousands of PPE for AMA physician members through a creative new collaboration with Project N95, a non-profit national clearinghouse for medical supplies.

The Current Procedural Terminology (CPT) Team issued 24 new or revised codes supporting COVID-19 care, guides and tools that were the most-downloaded documents from the AMA COVID-19 Resource Center.

The JAMA Network COVID-19 Resource Center provided access to a wealth of scientific resources on COVID-19 diagnosis and treatment, with a focus on information physicians could share with patients and their families. Expanded livestream and podcast portfolios contributed to a 40% surge in online traffic across the JAMA Network in 2020, representing some 190 million engagements.

Rapidly expanded video programming across AMA digital platforms, including 200 episodes of the popular daily AMA COVID-19 Update, resulted in a 900% increase in video minutes viewed in 2020.

More than 6.2 million users consumed nearly 10 million pages of content from the COVID-19 Resource Center, including more than 380,000 downloads of the 60 available guides for health care professions. The record 20 million unique visitors to the AMA website exceeded the combined total for both 2018 and 2019.

AMA partnered with American Heart Association and others on a national campaign to promote better heart health in Black women. The Release the Pressure campaign created culturally relevant resources to help Black women prioritize their blood pressure control and other aspect of self-care.

AMA collaborated with NORC at the University of Chicago to develop criteria for determining validated self-measured blood pressure devices and introduced a MAP blood pressure dashboard. The AMA MAP BP™ program and dashboard provides health care organizations a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender. The AMA MAP BP™ program and dashboard demonstrates a 10-percentage point increase in BP control in six months with sustained results at one year.

Only in its second year, the AMA's Enterprise Social Responsibility (ESR) program continues to deliver an organized and thoughtful structure to engage AMA employees in public service work aligned with the organization's values and goals. The program has strategically integrated within the OneAMA culture aligning "give back" opportunities at employee events and partnering with employee resource groups. Thirty-nine percent of AMA employees, representing every office location, logged over 2,500 volunteer hours, supported over 90 organizations and fundraised over $60,000.

Driving the future of medicine

AMA built upon strategic efforts to advance telehealth and improve physician well-being and practice sustainability during COVID-19 by developing dozens of free, online resources to help physicians better manage their mental health, keep their practices afloat, and foster widespread

adoption of remote patient care through the Telehealth Initiative, the Telehealth Implementation Playbook and accompanying resource guide.

The AMA successfully launched a new initiative for the AMA Masterfile, which integrates data from over 124 data sources and improves the clarity of race and ethnicity data.

AMA's Integrated Health Model Initiative (IHMII) received recognition within the digital health community for work in developing Social Determinants of Health (SDoH) and data standards and promoting interoperability. Rock Health selected AMA as top non-profit in digital health.

The AMA worked diligently to meet the needs of the medical education community during COVID-19. AMA developed the comprehensive AMA MedED COVID-19 resource guide as a centralized location to assist our educators, residents and students in keeping up with new information and providing resources, links and a community discussion forum. AMA produced a series of webinars addressing COVID-19's impact on medical education and produced guidelines for trainees and others practicing in the pandemic.

The AMA Accelerating Change in Medical Education Consortium and Reimagining Residency Initiative held a highly successful inaugural GME Innovation Summit virtually in October, with more than 400 attendees and over 200 presentations, workshops and posters. It included a shark-tank style Innovations Challenge, which resulted in the award of three new AMA GME Innovations grants.

The JAMA Network launched JAMA Health Forum, an online channel that addresses health policy and health strategy issues affecting medicine and health care, combining curated content from across the JAMA Network with weekly blog posts by leaders in health policy.

Health, Science and Ethics made significant strides in advancing the AMA's precision medicine work in 2020. Accomplishments include convening a cross-business unit collaborative team to align on strategy and implementation, partnering with the American Society of Health-System Pharmacists to develop a virtual summit series focused on the emerging area of pharmacogenomics and gathering data through physician surveys and environmental scans to inform future initiatives.

AMA Journal of Ethics received nearly four million annual visits. To help individuals and organizations navigate ethical challenges wrought by the pandemic, the journal established a COVID ethics resource center with new multimedia CME. While the pandemic disrupted much of normal life including the start of another medical school year, thousands of new students received a pocket edition of the *AMA Code of Medical Ethics* and possibly their first education of AMA's role in advancing the ethics of a profession.

AMA partnered with CDC on Project Firstline, a collaborative of diverse healthcare and public health partners that aims to provide engaging, innovative, and effective infection control training for frontline healthcare workers and members of the public health workforce. Project Firstline's innovative content is designed so that health care personnel can understand and confidently apply the infection control principles and protocols necessary to protect themselves, their facility, their family, and their community from infectious disease threats, such as COVID-19. Project Firstline content will be featured on the AMA Ed Hub™.

AMA Ed Hub™ expanded its offerings to feature courses on COVID-19, infection prevention and control, health equity, and physician burnout and wellness, contributing to a near 65% growth in views over 2019.

AMA's portfolio of education on AMA Ed Hub™ expanded to include more education from JN Learning, the *AMA Journal of Ethics* and *Code of Medical Ethics*, AMA Health Systems Science, AMA Steps Forward and CPT. Sixteen organizations have signed on to highlight their education on AMA Ed Hub with 6 new organizations launched in 2020 – including Obesity Medicine Association, Stanford Center for Continuing Medical Education, Howard Brown Health, Society of Hospital Medicine Education, American Society of Addiction Medicine and The Jackson Laboratory.

The AMA Center for Health Equity (CHE) worked to embed equity across the enterprise and throughout medicine by being among the first to call out the pandemic's missing data through a NY Times OpEd and Oprah-Apple TV. CHE launched the Prioritizing Equity Series, published a COVID-19 Latinx Report and established the Health Equity Resource Center on the AMA Ed Hub. AMA incorporated a diversity, equity and inclusion lens for all convened groups to support our work, including the CPT Editorial Panel, and developed training to better integrate health equity across the organization. AMA began training staff through Racial Equity Institute's phase one program, with plans to broaden the training across all staff in the months ahead.

AMA made a $1 million investment in a Chicago-based collaborative that focuses on addressing social determinants of health in an area of the city where life expectancy is far below the national average. The AMA will invest $2 million total over two years.

Membership

All the ways AMA supported physicians in 2020 contributed to another strong financial performance and a six percent membership surge, the 10th consecutive year of growth.

EVP Compensation

During 2020, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,185,918 in salary and $1,292,221 in incentive compensation, reduced by $2,462 in pre-tax deductions. Other taxable amounts per the contract are as follows: a $182,308 payment of prior years' deferred compensation, $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, $2,755 paid for parking and $3,500 paid for an executive physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2020 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-JUN-21

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2020 through February 2021

Presented by: Russ Kridel, MD, Chair

This report summarizes trends and news on tobacco usage, policy implications, and American Medical Association (AMA) tobacco control advocacy activities from March 2020 through February 2021. The report is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AND COVID-19

Early studies have linked certain underlying medical conditions with an increased risk for severe illness from the virus that causes COVID-19. The Centers for Disease Control and Prevention (CDC) publish an ongoing list of conditions for which sufficient evidence indicates the conditions are likely to cause or may cause more severe outcomes in adults with COVID-19. CDC includes smoking as a condition likely to increase COVID-19 severity, which has resulted in some states such as Illinois adding current/former smokers to vaccine priority status.

A literature review in *Respiratory Medicine* found that tobacco use in all forms, whether smoking or chewing, is significantly associated with severe COVID-19 outcomes. According to the authors, pre-existing comorbidities in tobacco users such as cardiovascular diseases, diabetes, respiratory diseases, and hypertension were found to further aggravate the virus making the treatment of such COVID-19 patients more challenging due to their rapid clinical deterioration. The authors conducted the literature review from August to September 2020.

TOBACCO USE AND HEALTH EQUITY

Study Looks at Menthol Cigarettes with a Social Justice Lens

Menthol could be exacerbating deep social inequities according to a paper published in *Nicotine & Tobacco Research*. Researchers at Columbia University Mailman School of Public Health and colleagues at CUNY and Rutgers School of Public Health suggest that a ban on menthol cigarettes could have monumental implications for both short- and long-term physical and mental health of communities of color. In 2009 the FDA banned cigarettes with certain flavors that appeal to children and teens such as bubblegum and chocolate. The FDA did not include menthol in that 2009 action stating it would be conducting more research, which FDA completed in 2011. FDA's scientific committee concluded that menthol in cigarettes increases initiation, facilitates progression to regular smoking, increases dependence, and decreases the likelihood of smoking cessation, especially among both youth and adult Black smokers, and as such, the removal of menthol from cigarettes would benefit public health. Overall estimates indicate that if menthol was included in the flavored cigarette ban, over 630,000 deaths would be averted, of which one of three would be a Black life. Despite the committee's conclusions, FDA has not taken action to ban menthol.

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Menthol has a cooling and anesthetic (or pain killing) effect. It can decrease the cough reflex and soothe the dry throat feeling that many smokers have. A study in the *American Journal of Public Health* found evidence that the tobacco industry was manipulating levels of menthol by promoting cigarettes with lower menthol content, which were popular with adolescents and young adults, and providing cigarettes with higher menthol content to long-term smokers. Studies have shown that the tobacco industry has targeted Black youth and adult smokers for decades resulting in lower quit rates attributable to menthol. This connection between low quit rates in Black menthol smokers was also confirmed by the FDA's own findings.

AMA Joins in Lawsuit Against FDA

The American Medical Association joined the African American Tobacco Control Leadership Council and Action on Smoking and Health as co-plaintiffs in a lawsuit against the FDA. The complaint, initially filed in June 2020, requests that the court compel the FDA to fulfill its mandate to take action on FDA's own conclusions that it would benefit the public health to add menthol to the list of prohibited characterizing flavors and therefore ban it from sale.

In November 2020, the court denied the FDA's motion to dismiss the complaint, thus allowing the case to proceed to discovery. Following the decision, the National Medical Association was added as a plaintiff, and the FDA is currently working on a response to the citizen petition addressing their inaction on menthol to date.

OTHER EFFORTS TO ADDRESS TOBACCO CONTROL

AMA Supports Increased Funding for Tobacco Control Policy and Programs

The American Medical Association called on the U.S. Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to increase funding for the CDC Office on Smoking and Health by $80 million. In a letter to then-subcommittee chair Senator Roy Blunt and then-ranking member Senator Patty Murray, health care organizations, medical associations and public health groups cited the rising increase in e-cigarette usage by teens and young adults and the continued toll that tobacco takes on the health of the nation.

The letter outlined that the added funds would allow CDC to effectively respond to the youth e-cigarette epidemic, including providing more resources to state and local health departments, expand its Tips from Former Smokers® (Tips®) media campaign and strengthen efforts to assist groups disproportionately harmed by tobacco products.

USPSTF Releases Updated Recommendations for Treating Tobacco Dependence in Adults including Pregnant Women.

To update its 2015 recommendation on smoking cessation, the USPSTF commissioned a review to evaluate the benefits and harms of primary care interventions on tobacco use cessation in adults, including pregnant persons. The updated recommendation reflects newer evidence and language in the field of tobacco cessation and includes a description of the 2019 E-cigarette or Vaping product use Associated Lung Injury, or EVALI, outbreak in the U.S. However, the recommended services that primary care clinicians should provide for tobacco cessation are the same as in 2015. The USPSTF continues to recommend that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. Pregnant women should be asked about tobacco use, advised to stop using tobacco, and provided behavioral interventions for cessation. There

remains insufficient evidence to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons.

The USPSTF concludes that the evidence on the use of e-cigarettes for tobacco smoking cessation in adults, including pregnant persons, is insufficient, and the balance of benefits and harms cannot be determined. The USPSTF identified the lack of well-designed, randomized clinical trials on e-cigarettes that report smoking abstinence or adverse events as a critical gap in the evidence. The 2020 update was published in the January 19, 2021 issue of *JAMA*.

CDC's Tips® Campaign Increases Quit Rates

Findings from a CDC study published in *Preventing Chronic Disease* show that CDC's Tips® campaign led more than 1 million U.S. adults to quit smoking and an estimated 16.4 million U.S. adults to attempt to quit smoking during 2012–2018. To assess the campaign's impact on quit attempts and sustained quits, CDC analyzed data from a nationally representative longitudinal survey of U.S. adults who smoked cigarettes during 2012–2018.

The Tips® campaign was launched in 2012 and shows real people who are living with serious long-term health effects from cigarette smoking and secondhand smoke exposure. Through the campaign, people share compelling stories about their smoking-related diseases and disabilities and the toll these conditions have taken on them. The campaign also features nonsmokers who experienced life-threatening episodes because of exposure to secondhand smoke and family members affected by their loved one's smoking-related illness.

The 2020 U.S. Surgeon General's Report on Smoking Cessation cites studies showing that emotionally evocative, evidence-based campaigns like Tips® are effective in raising awareness about the dangers of smoking and helping people who smoke to quit.

TOBACCO USE SURVEILLANCE

CDC Morbidity and Mortality Weekly Reports (MMWR)

Cigarette smoking is responsible for more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. From March 2020 through February 2021, the CDC released eight MMWRs related to tobacco use. These reports provide useful data that researchers, health department, community organizations and others use to assess and develop ongoing evidence-based programs, policies, and interventions to eliminate and/or prevent the economic and social costs of tobacco use including electronic cigarettes.

Monitoring E-cigarette Usage Among Teens to Identify Strategic Control Policies

The September 18, 2020, and October 23, 2020, MMWR both highlighted e-cigarette use among youth, emphasizing the increased popularity of "pod mods," which are products with a prefilled or refillable pod cartridge (pod) and a modifiable (mod) system. According to the report in the September 18 MMWR, e-cigarettes have been the most used tobacco product among U.S. youths since 2014 with 27.5% of high school students reporting current e-cigarette use in 2019. To assess trends in unit sales of e-cigarettes in the U.S. by product and flavor type, the CDC, the CDC Foundation, and Truth Initiative analyzed retail scanner data. By product type, the proportion of total sales that were prefilled cartridge products increased from 47.5% to 89.4% during September 2014–August 2019. The authors of the October 23 MMWR study noticed that the rise in pod mods coincided with the increased usage of e-cigarettes by youth. The popularity of the pod mods is due

in part to the e-cigarette industry marketing the use of nicotine salts instead of freebase nicotine. Freebase nicotine is used in most other e-cigarette cartridges, or vaping, products and conventional tobacco products (e.g., cigarettes). According to the study, nicotine salts, which have a lower pH than freebase nicotine, allow particularly high levels of nicotine to be inhaled more easily and with less irritation to the throat than freebase nicotine. The most commonly sold pod mod brand is JUUL, which accounted for 75% of all U.S. e-cigarettes sales by the end of 2018. A majority (59.1%) of U.S. high school student e-cigarette users report JUUL is their usual brand.

Continued monitoring of e-cigarette sales and use is critical to inform strategies to minimize risks. As part of a comprehensive approach, such strategies could include those that address product innovations and flavors that appeal to youth.

Prevalence and Trends in Cigarette Smoking Among Adults with Epilepsy - United States, 2010–2017.

Studies have shown that cigarette smoking is as common, and sometimes more so, among adults with a history of epilepsy compared with those without a history of epilepsy. According to the prevalence report in the November 27, 2020 MMWR, citing the latest available data, from 2010–2017, one in four adults with active or inactive epilepsy were current smokers, compared with one in six persons without epilepsy. Compared with adults without epilepsy, adults with epilepsy report lower household income, more unemployment and disability, worse psychological health, and reduced health-related quality of life. This report is the first assessment of smoking trends in people with epilepsy. While cigarette smoking declined significantly among adults without a history of epilepsy, from 19.3% in 2010 to 14.0% in 2017, declines in current cigarette smoking among adults with active epilepsy were not statistically significant (from 26.4% to 21.8%). This lack of a significant decrease in people with epilepsy provides an intervention opportunity. Health and social service providers who interact with persons with active epilepsy should ensure that smoking cessation information and resources are available to them.

REPORT 8 OF THE BOARD OF TRUSTEES (June 2021)
Plan for Continued Progress Toward Health Equity
(Center for Health Equity Annual Report)
(Informational)

EXECUTIVE SUMMARY

In accordance with Policy D-180.981, this informational report outlines the equity activities of our AMA from 3rd Quarter 2020 through the 2nd Quarter of 2021, with some projections into the 3rd Quarter of 2021.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-JUN-21

Subject: Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report)

Presented by: Russ Kridel, MD, Chair

BACKGROUND

This report is the second of its kind submitted for information to the House of Delegates, following Report 15 from the November 2020 Special Meeting. In June 2018, the House of Delegates adopted Policy D-180.981, "Plan for Continued Progress Toward Health Equity," directing our AMA to develop "an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities." Since the 2019 establishment of our AMA Center for Health Equity ("the CHE", "the Center"), our AMA continues to make advances in embedding equity in medicine and in public health. This report illustrates those internal activities and strategies, as well as alludes to external events of year 2020 through half of 2021, which deepened and hasten our AMA's commitment to equity across what will assuredly be known as a fateful year in the nation and in the world.

DISCUSSION

Deepening the Case for Strategic Equity

The 2020 Center for Health Equity Annual Report emphasized our AMA's commitment to an enterprise-wide core equity strategy. Within the first year of its inception, the CHE set in motion tremendous efforts and activities that garnered international attention to the equity work of our AMA, particularly considering the impact of the coronavirus SARS-CoV-2, COVID-19. Our membership is at the front lines within clinical spaces, and also in spaces to bolster equity-driven responses as the virus persistently and disproportionately impacts elders and historically racially marginalized and minoritized persons. Additionally, the nation and our AMA now grapple with the equitable distribution of the COVID-19 vaccines; the significant impact of a change in presidential administration; as well as ongoing racially-motivated hatred, tensions, and violence. Each of these factors is external to the activities of the AMA, but clearly impacts how our association positions itself as a national leader in medicine and equity. Simultaneously, our AMA's internal efforts to strengthen staff and membership dexterity and commitments to health equity are in full force. Yet, the fragility of these new efforts is clear, and these efforts are susceptible to any episodic threats that undermine our AMA's work to advance and center equity. The March 2021 *JAMA* podcast titled "Structural Racism for Doctors—What Is It?" is one such harmful episode that caused many to question the core equity commitment of our AMA by rejecting the existence of structural racism. And, while the AMA and *JAMA* are separate entities, that episode has rocked our AMA's public credibility in the equity space, not just the work completed over the two years of the CHE's existence, but across the course of championship for equity within the AMA ranks over the last 20 years. This is not to say there is no space for healthy questioning when there is ignorance about what structural racism is, but there must be no tolerance for stances that perpetuate misinformation and debate the realities of structural racism in medicine and beyond. Thus, in addition to outlining

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the equity milestones of the last year, this 2021 report is also staunchly determined to demonstrate our AMA's deepened commitment to uplift health equity, and thwart all threats—external and internal—to that commitment.

THE AMA EQUITY QUARTER SUCCESSES AND MILESTONES

3rd Quarter, 2020

(1) Equity in Advocacy: Internal Impact
Three-Module Immersive Workshop Series

Between summer 2020 and through the end of the year, the CHE embarked on an internal, immersive assessment and subsequent immersive skills building workshop series specifically designed for our AMA Advocacy business unit (BU). This work was a follow up to a November 2019 – February 2020 environmental qualitative assessment primarily of the Washington, D.C. office readiness for embedding equity throughout Advocacy processes. As referenced in last year's report, this assessment led to the *Proposed Health Equity Policy & Advocacy Future State, Goals & Key Deliverables 2020 2025*, referred hereafter as "the Report," which the CHE handed over to the AMA Advocacy leadership for consideration. By summer 2020, the next step was to conduct an *Equity in Advocacy and Policy Needs Assessment*, referred to as "the Assessment," which extended the work of the Report. The Assessment captured the skills that could be strengthened among members of the AMA Advocacy team concerning their knowledge base and application of health equity to all aspects of their policy and advocacy work. Between the Report and the Assessment, CHE staff Mia Keeys, Director of Health Equity Policy and Advocacy, and Joaquin Baca, Senior Health Equity Policy Analyst, developed the Supplemental Health Equity in Advocacy and Policy Immersive Development, Training, & Engagement Curriculum, referred hereafter as "the Curriculum." The purpose of the immersive development, training, and engagement program was to imbue advocacy and policy day-to-day tasks with equity practices. The Curriculum consisted of three, separate full-day or half-day immersive workshops exclusively for Advocacy staff of both the Chicago and Washington, DC offices.

At the end of the workshop series, participants were able to: define health equity in a way that differentiates it from other terms such as health disparities, health inequalities, and health inequity in discussions, written work, and presentations; explain how adopting an equity mindset is essential to all aspects of advocacy work; and apply an equity lens to policy analysis, development, and promotion with proficiency in a normal work environment. Table 1 in the Appendix further outlines the descriptions of each Module.

(2) Equity in Advocacy: External Impact
AMA Congressional Activities

In addition to the internal work that CHE staff executed with the Advocacy BU, Center staff also supported pivotal Congressional activities. In June 2020, AMA Immediate Past President Dr. Patrice A. Harris delivered Congressional testimony to the House Budget Committee Hearing, *Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change*. Her words garnered gratitude from Kentucky Representative John Yarmuth, who is also the Congressional Representative of the slain Breonna Taylor. As we near the year anniversary of her murder by police, we may also reflect on Dr. Harris's testimony, which the CHE was instrumental in crafting and reviewing alongside Advocacy and Enterprise Communications.

In summer 2020, the House Committee on Ways and Means Chairman Richard Neal (D-MA) released to AMA and several other societies/organizations a letter spurred by a *New England Journal of Medicine* (NEJM) article on race and clinical algorithms. The letter called on professional medical societies to push racial health agenda forward and requested information on the misuse of race within clinical care. The Advocacy BU led to response effort, with substantial CHE support under the auspices of one of our driving strategic approaches, embedding equity across health innovations.

As outlined in last year's CHE report, the CHE had written Congressional bill language calling for the collection of equitable data regarding COVID-19 testing, namely race/ethnicity and preferred spoken/written language. Parts of H.R. 6865, the Equitable Data Collection and Disclosure Act were eventually included into the CARES Act, the first COVID-19 relief package. In late Quarter 3, the AMA submitted a "thank you" and an official endorsement letter to the bill's primary sponsor, Rep. Robin Kelly (D-IL). Equitable collection of REI data continues to be a major problem, but now with respect to COVID-19 vaccination distribution. The CHE, alongside Advocacy, continues to ring the alarm about REI data collection, but now with respect to COVID-19 vaccine distribution. (In February 2021, the AMA, American Nurses Association, and the American Pharmacists Association released a letter calling for a bolstering of REI data on COVID-19 vaccine distribution.)

(3) The CHE has also been working with the Office of General Counsel (OGC) to ensure that AMA works to advance equity within judicial settings. For example, the AMA, alongside African American Tobacco Control Leadership Council (AATCLC), Action on Smoking and Health (ASH), and the National Medical Association (NMA), joined a lawsuit against the FDA, mandating action on banning menthol cigarettes. The suit was filed on June 17, 2020 in the United States District Court in Oakland, California and asserts that contrary to the duties imposed by the Family Smoking Prevention and Tobacco Control Act ("Tobacco Control Act"), the FDA failed to act on menthol cigarettes, and requires the FDA to ban menthol cigarettes or, in the alternative, to give a public, cogent explanation of their reasoning. The title of the case is *African American Tobacco Control Leadership Council, Action on Smoking and Health, and American Medical Association v. U.S. Department of Health and Human Services, et al.* Given that addiction to menthol cigarettes has been cited as highest among youth, and associated with higher rates of smoking frequency and death amongst African Americans, the health equity implications of menthol cigarettes are heinous. The CHE and OGC also collaborate in judicial advocacy on other equity issues such as sugar-sweetened beverages, the opioid crisis, LGBTQ protections, reproductive justice, immigration-related issues, and evictions and housing, among others.

(4) Conducted in collaboration with the Environmental Intelligence, Survey and Market Research (EISAMR) BU, the Minoritized & Marginalized Physician Survey captured the barriers that historically marginalized and minoritized physicians face/have faced in delivering care during the pandemic of COVID-19. CHE prioritized sharing these initial insights with internal BUs and workgroups to inform their efforts to support the unique needs of historically marginalized and minoritized physicians. These insights have been shared with the Telehealth Working Group, the Internal LGBTQ+ Working Group and the LGBTQ Advisory Committee. Current efforts include creating a series of external reports illuminating the experiences of racially minoritized physicians and of LGBTQ+ physicians by end of second quarter of 2021. Efforts to highlight the experiences of physicians with disabilities will begin the second quarter of 2021.

(5) In May 2020, the Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation asked the CHE to review and provide feedback on newly revised 10 Essential

Public Health Services (EPHS) framework. The original 10 Essential Public Health Services (EPHS) framework was developed in 1994 by a federal working group. It serves as the description of the activities that public health systems should undertake in all communities. Health departments and community partners around the nation organize their work around the EPHS framework; schools and programs of public health teach it; and the framework informs descriptions and definitions of practice. The framework is also used as the basis of the Public Health Accreditation Board Domains. The framework has provided a roadmap of goals for carrying out the mission of public health in communities around the nation. However, the public health landscape has shifted dramatically over the past 25 years, and many public health leaders agreed it was time to revisit how the framework can better reflect current and future practice and how it can be used to create communities where people can achieve their best possible health. The CHE contributed significantly to the new framework and submitted its suggestions in August 2020, which may be found here.

(6) The Center for Health Equity. Human Resources, Enterprise Communications, and Environmental Intelligence business units worked together to launch the inaugural All Employee Engagement and Equity Assessment. The objective of the assessment was to understand and enhance employee engagement and satisfaction, ensure an equitable and inclusive workplace for all employees, and advance health equity through the organization's external efforts. The core AMA assessment team worked with outside consultants to design and field a survey that launched in July 2020 and garnered a response rate of 92.35% (1,099 of 1,190 employees). The survey was followed by a series of focus groups to further amplify the voices of demographic groups with the lowest engagement rates based on survey results. A detailed report of the AMA All Employee Engagement and Equity Survey results was published internally and used to engage in dialogue with employees across the organization, including enterprise-wide, within BUs, and with Employee Resource Groups. A roadmap for enterprise-wide and BU action planning was shared.

(7) With the addition of Chelsea Hanson as Director of Health Equity & Innovation to the Center in summer 2020, work began in earnest on internal and external stakeholder discussions and landscape analyses to inform the Center's "Ensure equity in innovation" approach.

4th Quarter, 2020

(1) Historic Passage of Three Anti-Racism HOD Policies

The Center commends the outstanding work of the AMA Medical Student Section (MSS), the Minority Affairs Section (MAS), and the Women Physicians Section for their work in introducing three legacy antiracism policies, which were adopted during the November 2020 Special Meeting of the AMA House of Delegates. The mark of these three outlined policies—H-65.952, "Racism as a Public Health Threat, AMA Health Policy"; H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, AMA Health Policy"; and D-350.98, Racial Essentialism in Medicine"—is indelible. Following the passage of these policies, the Chief Health Equity Officer published an article in *Essence* magazine to emphasize its significance.

The passage of these policies will facilitate the AMA's stronger support of congressional, federal, and state level antiracist policies. The CHE anticipates working closely with Advocacy to leverage these policies toward the effect.

During this historic HOD session, Dr. Maybank and other CHE staff were invited to present to several sections on health equity topics. This included presentations to the Medical Student Section, the International Medical Graduates Section, and the Senior Physicians Section.

(2) Health Equity Learning Series and Health Equity Spotlight Modules

Under the CHE leadership of Alice Jones, Program Manager, Health Equity Performance and Operations, the AMA is intentionally expanding its focus on inequities associated with disabilities, which was not a strong focus of the CHE until recently. The Access Health Employee Resource Group (ERG) Series were carried out between November and December 2020. Disability 101 focused on basic concepts related to identifying as disabled, including stigma, etiquette, and explanation of Social vs Medical Models of Disability. Disabilities at Work highlighted how to be inclusive, and emphasized hiring and retaining, and reasonable accommodations. The Disability Now and Then workshop gave an overview of social context for people with disabilities (ADA, contemporary issues with accessibility despite the ADA). The work of the ERG draws attention to the spaces our AMA must still address with respect disability equity across the AMA workforce, as well as in medicine, in general. In the future, the CHE looks forward to reviewing, evaluating, and providing feedback on AMA's handling of reasonable accommodations (including ones for electronic accessibility standards) for both new hires and for existing staff. Table 2 in the Appendix lists AMA policies relevant to disabilities and reasonable accommodations.

Also, under co-leadership of CHE and Health Solutions, creation of some educational opportunities around gender identity and non-binary pronouns. The group developed a modules to support staff's developing confidence and ease with sexual orientation and gender identity.

(3) Two critical efforts in support of the "Ensure Equity in Innovation" approach were completed. The first, in October 2020 was the formation and launch of an AMA External Equity & Innovation Advisory Group comprised of 11 experts at the intersection of health equity and innovation, a diverse group of leading physicians, entrepreneurs, investors, and advocates for the health and wellbeing of historically marginalized and minoritized communities. The group held its first quarterly meeting with CHE leadership and began to formulate its collective vision and values. The second effort was the completion and publication of an analysis of twenty-five interviews of internal AMA, Health2047, and Health2047 Capital Partners innovation stakeholders conducted by Center for Health Equity consultant, Braven Solutions, to understand opportunities to support the embedding of equity into existing innovation efforts across our ecosystem.

(4) Toward the end of 2020, CHE, under the planning of Denard Cummings, the CHE Director of Equitable Health Systems Integrations, collaborated with HealthBegins to develop the AMA Upstream Strategy Primer to support the ongoing work of the AMA Social Determinants of Health Workgroup. The CHE is executing the Upstream Strategy with PS2, IHMI, and EISAMR. The role of the Upstream Strategy is to leverage the existing AMA policies on social determinants of health and public health to move AMA's interventions closer to the foundations of avoidable inequities in health.

(5) Our AMA is making strides with respect to written language equity. While there is much room to grow, the CHE's own Dr. Diana Derige and Dr. Diana Lemos led the work with Enterprise Communications on our AMA's Hispanic Heritage Month campaign, one of the first AMA entirely bilingual campaigns. The final product was a multimedia news release and resource for media outlets to consume and report on our AMA content produced in English and Spanish.

Drs. Derige and Lemos were also deeply instrumental in producing The AMA Latinx Health Inequities Report, which reports on Latinx ethnic data and uncovers the true magnitude of COVID-19 on the Latinx community.

(8) Another notable accomplishment has been the creation of the AMA internal Language Access Plan, also led by CHE staff. The Language Access Plan includes best practices and guidance to support an inclusive AMA policy to ensure access under Language Access Obligations Under Executive Order 13166 and meaningful access for limited English proficient persons under the national origin nondiscrimination provisions of Title VI of the 1964 Civil Rights Act. Our AMA Health Equity Initiatives Webpage went live in September 2020. It features content from healthcare, governmental and community organizations across the country that are working to provide resources to minoritized and marginalized populations, dismantling racist systems and improving patient trust in the health care system. The CHE partnered with these organizations to collect their insights to help our AMA better understand the history of the project or initiatives, the overall goals of the projects and initiatives, the expected results and early wins, as well as the key partners involved in the effort.

(9) In November 2020, the CHE hired Gina Hess as Operations Assistant. Amongst other pertinent organizational capacity work, Ms. Hess tracks the CHE team's information for presentations, keynotes, and panels, and co-coordinates the bi-weekly Prioritizing Equity Series with Aziza Taylor, CHE's Communications and Marketing Manager, and with the Digital Strategy and Operations team of Enterprise Communications.

The equity work of the AMA has greatly benefitted from burgeoning health equity leaders, including CHE interns. In six months time (May-November 2020) the first CHE intern, Brian De La Cruz, a graduate student from Wheaton College, was instrumental in the early organization and execution of the Prioritizing Equity series. He built a database for Prioritizing Equity series records, which reflect not only the date and time specifics of the YouTube series but also its episode panelists, viewership statistics and social media impact. Mr. De La Cruz also supported the CHE Performance and Operations, and Marketing and Communications teams to help create a workflow for processing the Prioritizing Equity honoraria for guest speakers, and helped to revamp the CHE Sharepoint site.

The CHE collaborated with the AMA Federation Relations team to engage with the Federation of Medicine on December 2, 2020. Dr. Maybank presented on the mission and goals of the CHE as well reporting on recent activities and plans for 2021. The plans include a deeper and sustained engagement with Federation members through regularly scheduled meetings where Federation members may highlight their health equity activities with each other and potentially collaborate on common efforts.

(10) Starting in 2020 and continuing into 2021, CHE has contributed expertise to the google.org-backed Health Equity Task Force convened by Dr. Daniel Dawes, Satcher Health Institute. The Task Force is guiding the creating of a public-facing health equity tracker, with the goal of providing accessible and impactful data to a wide range of users. CHE staff represented two different subcommittees within the Task Force—the Data Consortium and the Population-Based Strategies Work Group.

(11) As the year came to a close, the CHE continued to expand the equity presence and visibility of the AMA. Since 2020, CHE staff have delivered keynotes and moderated panel conversations close to 160 in number. Table 3 in the Appendix outlines these events.

1st Quarter, 2021

January 2021 brought with it upheaval with the siege of the nation's Capitol building, and ongoing suspicions of threat to the country's symbol of democracy. At the same time, the change in the presidential administration offers opportunities to centering health equity at the national stage. This season of change requires physician-advocate leadership—leadership which the AMA through the CHE and other business units, is creating through various physician-supporting programs.

(1) Referred to in the first CHE BOT Report as the Health Equity Advocacy and Leadership (HEAL) Fellowship, the AMA and Morehouse School of Medicine Satcher Health Leadership Institute's Medical Justice and Advocacy Fellowship is underway. The Medical Justice in Advocacy Fellowship is a collaborative educational initiative to empower physician-led advocacy that advances equity and removes barriers to optimal health for marginalized people and communities. The fellowship will mobilize physicians to be part of the next generation of advocacy leaders, driving meaningful policy and structural changes that produce equity and justice in the communities they serve. By July 2021, it will have selected its first 10-member cohort. Diana Derige, and several other CHE staff, coordinated the internal AMA team—including staff from Advocacy, Ed Hub, Marketing and Member Experience (MMX), Improving Health Outcomes (IHO), Medical Education, Health and Science, and Payment and Quality, to see this vast effort into fruition.

(2) The Women's Equity and Leadership program (WEL) will foster the development of the next wave of female physician leaders to build a healthier, more equitable work experience. WEL is a collaboration of ten health care organizations: the American Academy of Pediatrics (administrator), American Academy of Family Physicians, American College of Physicians, American College of Obstetricians and Gynecologists, American Hospital Association, American Medical Association, American Medical Women's Association, American Psychiatric Association, National Hispanic Medical Association, and National Medical Association, who will each contribute 5 participants to the 2021 cohort (total 50.)

(3) The CHE advances the AMA's commitment and cause to making plain and accessible the significance of equity in health, using myriad multi-media platforms. In continued collaboration with the Marketing and Member Experience (MMX) BU, the CHE commenced Season 2 of "Prioritizing Health Equity," on the AMA's YouTube channel. To date, 26 episodes have been produced, with more than 137,000 views. While the intent of the series remains unchanged since its inception, the co-producing business units vary each episode not only in subject focus, but also by episode length, at either 30 minutes, 45 minutes, or 1-hour. Table 5 reflects the AMA Prioritizing Equity episodes to date, listed from most recent to most dated.

Table 4 of the Appendix lists the books, research papers, and other notable publications produced by CHE staff, over the last year. These include a book, *Unequal Cities: Structural Racism and the Death Gap in America's 30 Largest Cities*, published by the Johns Hopkins University Press as part of its "Health Equity in America" series. CHE members have also co-authored articles in leading scholarly journals, including the *Lancet*, *Health Affairs, JAMA Network Open*, the *American Journal of Preventive Medicine*, and *Public Health*.

In progress are an edited book on structural competency and the COVID-19 pandemic (co-edited by Aletha Maybank, Fernando De Maio, Jonathan Metzl and Uché Blackstock) and an edited theme issue for the *AMA Journal of Ethics* (Fernando De Maio, Diana Derige, and

Diana Lemos) bringing together nine cases/papers from leading scholars of Latinx health equity.

(4) Between January and March 2021, several new members joined the team. Karthik Sivashanker, MD, MPH, CPPS, joined as Vice President of Equitable Health Systems and Innovation. He also serves as the Medical Director of Quality Safety and Equity of Brigham Health. Joni Wheat joined the team as our Program Administrator. Dr. Zain Al Abdeen Qusair and Dr. Iqra Hashwani joined as interns from DePaul University's Master of Public Health program, working under the supervision of Fernando De Maio, PhD, Director of Research and Data Use. The bolstering of the CHE team strengthens the AMA's national position as equity brokers in medicine and public health. CHE secured a memorandum of understanding (MOU) with Northwestern University's Public Health program to increase intern support for the team and to expand opportunities for MPH and MD/MPH students to learn and contribute to the work of the Center.

(5) The AMA External Equity & Innovation Advisory Group reconvened with the Center for Health Equity for its second quarterly meeting in February 2021. The group engaged in interactive breakout discussions that included AMA and Health2047 innovation stakeholder participants.

(6) CHE is working in partnership with Health Solutions and Medical Education on strengthening race and ethnicity data collection in the AMA Masterfile, and with the explicit purpose of building a data foundation toward a more equitable health system. Under the leadership of Fernando De Maio, CHE worked with Kenyetta Jackson of Health Solutions to execute the first ever Physician Data Collaboration Summit in February 2021, a meeting with internal stakeholders across the AMA business units, and with external steering committee, including representatives from the ACGME and AAMC. The group continues to meet in 2021, with the goal of establishing common data standards and definitions and a collaborative research agenda examining diversity of the physician workforce.

The AMA, led by CHE, submitted a proposal for the global challenge address Racial Equity 2030. The RFP called for bold solutions to drive an equitable future for children, their families and communities. Our proposal aims to address medicine's historical production of scientific, cultural, structural, and institutional racism and dismantle its roots; centering restorative and "just" healthcare and meaningfully engages all voices to fundamentally change medicine and the health of our nation.

(7) Working with the American College of Preventive Medicine, CHE responded to an open request for proposals to support solo or small group practices of racial and ethnic minority physicians to accelerate the capacity of implementing COVID-19 prevention, testing, and vaccination strategies within racial or ethnic minority communities. Under the Centers for Disease Control and Prevention (CDC), this is the OT18-1802 Cooperative Agreement, "Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health Improving Minority Physicians' Capacity to Address COVID-19 Disparities". The intent of this work is to increase physicians' ability to capture and collect case studies and to engage patients in impactful conversations about COVID-19 and to make resources available to their patients. For the first time in its 174-year history, our AMA is producing a strategic roadmap that outlines a framework to address inequities in health care. Given the enormity of work that achieving health equity entails, it is critical for the American Medical Association to outline, define and chart a path to success to allow us to not only monitor our progress but to also facilitate transparency, accountability, and continuous quality

improvement in the process. The plan is aligned with the Center for Health Equity's five strategic approaches: embed equity; build alliances and share power; ensure equity in innovation; push upstream; and create pathways for truth, racial healing, reconciliation, and transformation.

2nd Quarter, 2021 and 3rd Quarter 2021 Projections

(1) The Board's first report to the House of Delegates on the CHE gave the early outline for what will henceforth be referred to as the Centering Equity in Emergency Preparedness and Response Recovery Initiative for Healthcare (the CEEPRR). The CEEPRR is created in partnership between our AMA and confirmed partners, including the Planned Parenthood Federation of America (PPFA), American College of Preventive Medicine (ACPM), American Public Health Association (APHA), National Medical Association (NMA), National Hispanic Medical Association (NHMA), GLMA, American Association of Public Health Physicians, America's Essential Hospitals, American Academy of Family Physicians, and the National Birth Equity Collaborative. The CEEPRR will serve as a resource for healthcare professionals and for healthcare organizations to embed and implement equity strategies and tactics to prepare and respond to emergencies. There is a dearth of guidance and community in healthcare in this domain. The initial product will include a guide/playbook with guiding principles, critical shared terminology, and illustrative case studies. There will be opportunities to extend this asset via other amplifying opportunities such as the Ed Hub. The CHE is using a collaborative approach to inform product development, innovation, and amplification. This initiative will be the first of its kind and a unique opportunity to promote and establish more equitable policies, practices and service behaviors across healthcare. The anticipated release date is for May 2021.

(2) The "Ensure equity in innovation" strategy will continue to be developed with the guidance of the AMA External Equity & Innovation Advisory Group and through market research and stakeholder engagement that centers the voices of patients, innovators, and investors from historically marginalized and minoritized communities. This research and stakeholder engagement will inform collaborative strategic initiatives and policies, internal training and tools, and external industry-facing content and resources to be launched in 2021 and beyond.

APPENDIX

TABLE 1: Health Equity in Advocacy and Policy Immersive Development, Training, & Engagement Curriculum Modular Description

Training at a Glance

Module 1: Why an Equity Mindset is Essential to Work in Policy and Advocacy

- History – how policy decisions have created and reinforce inequity
- Examples of Unintended/Unrecognized/Ignored Consequences of policy
- Implicit and Explicit Bias
- Business and Productivity Case for Equity in Policy/policy and Advocacy

Module 2: Foundational Concepts in Health Equity, the Medical Justice in Advocacy Fellowship, and equity in advocacy agenda-setting

- Definitions of SDOH, Health Equity, Anti-racism, etc…
- Review of social, structural, political determinants of health
- The Medical Justice in Advocacy Fellowship overview
- Equity agenda-setting in bi-partisan arenas

Module 3: Review of Equity-based Policy Analysis/Decision Support Tools

- Health Equity Impact Assessment (HEIA)
- Intersectional Policy Analysis
- Applying an Equity Lens: Recognizing Equity Issues in sample policy-evaluations, testimonies, letters, etc…

TABLE 2: DISABILITIES RELEVANT AMA POLICY

POLICY DISTINCTION	TITLE	DESCRIPTION
D-90.991	"Advocacy for Physicians with Disabilities,"	1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA. 2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration. 3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.
H-65.965	"Support of Human Rights and Freedom,"	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.
D-180.991	"Work Plan for Maintaining Privacy of Physician Medical Information"	The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities.

H-90.987	“Equal Access for Physically Challenged Physicians,”	Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.
H-200.951	“Strategies for Enhancing Diversity in the Physician Workforce,”	Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
9.5.4	Civil Rights & Medical Professionals	Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.
	AMA Principles of Medical Ethics: IV: Balance with patient safety	

TABLE 3: CHE Keynotes, Panels, and Other Speaking Engagements

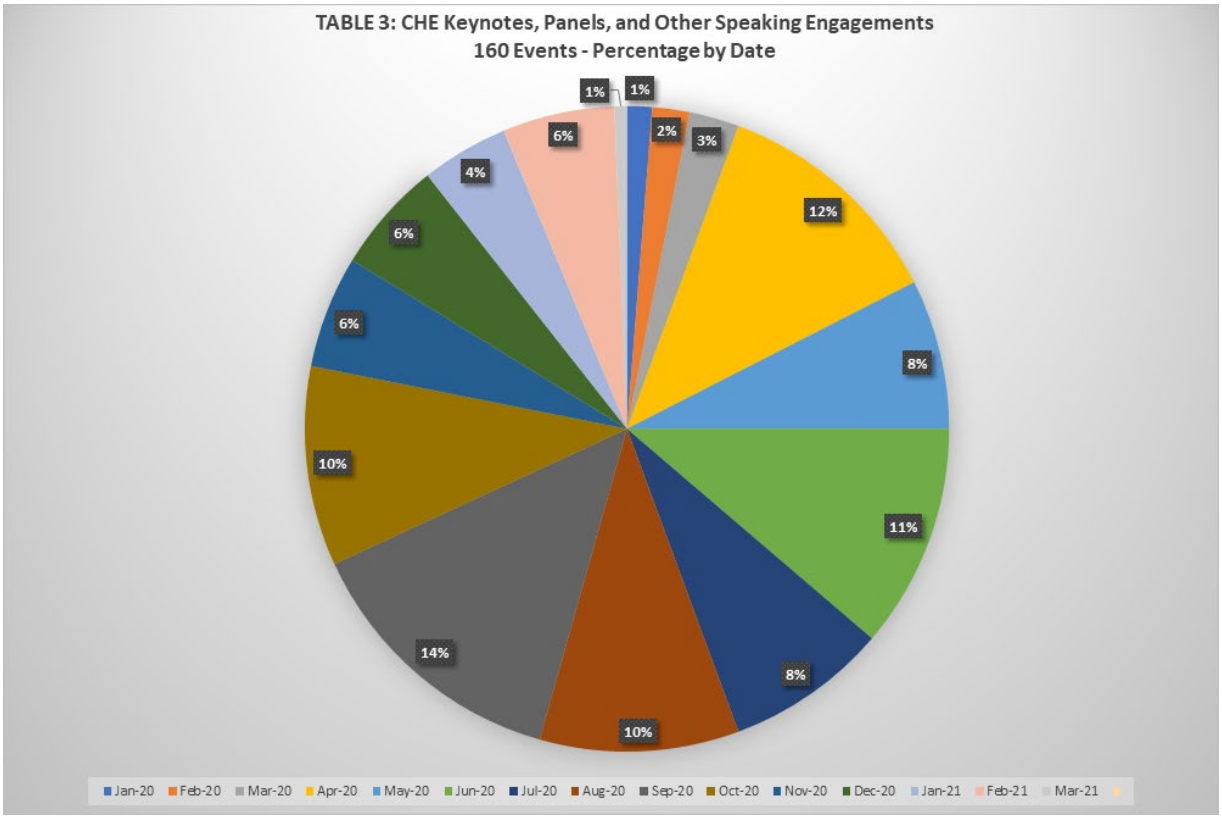

TABLE 4: CHE Peer-Reviewed Publications

AUTHORS	YEAR	TITLE	JOURNAL
Metzl, **Maybank**, and **De Maio**	2020	Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System	JAMA
Crear-Perry, **Maybank**, **Keeys**, Mitchell, and Godbolt	2020	Moving towards anti-racist praxis in medicine	Lancet
Schober, Hunt, Benjamins, Silva, Saiyed, **De Maio**, and Homan	2020	Homicide Mortality Inequities Across the 30 Biggest Cities in the United States	American Journal of Preventive Medicine
Bishop-Royse, Lange-Maia, Murray, Shah, and **De Maio**	2021	Structural racism, socio-economic marginalization, and infant mortality	Public Health
Benjamins, Silva, Saiyed, and **De Maio**	2021	Comparison of All-Cause Mortality Rates and Inequities Between Black and White Populations Across the 30 Most Populous US Cities	JAMA Network Open
Liao and **De Maio**	2021	Social Inequality, Political Factors, and COVID-19 Infections and Deaths Across US Counties	JAMA Network Open
Richardson, Malik, Darity, Mullen, Morse, Malik, **Maybank**, Bassett, Farmer, Worden, and Jones	2021	Reparations for American Descendants of Persons Enslaved in the U.S. and their Potential Impact on SARS-CoV-2 Transmission	Social Science and Medicine
Khazanchi, Crittenden, Heffron, Manchanda, **Sivashanker, and Maybank**	2021	Beyond Declarative Advocacy: Moving Organized Medicine And Policy Makers From Position Statements To Anti-Racist Praxis	Health Affairs Blog
Keeys, Baca, and Maybank	in press	Race, Racism, and the Policy of 21st Century Medicine	Yale Journal of Biology and Medicine

Note: CHE authors in bold

TABLE 5: Prioritizing Equity Series

Table 5: Prioritizing Equity Series	DATE
COVID-19 & Minoritized Physicians	3/11/2021
COVID-19 & Trauma Informed Approaches	2/25/2021
COVID-19 & Disability	2/11/2021
COVID-19 Vaccine & Equitable Distribution	1/28/2021
After Show: Trustworthiness and Vaccines	12/10/2021
Trustworthiness and Vaccines	12/10/2020
Research and Data for Health Equity	11/19/2020
2020 Election - Moving Forward	11/12/2020
Examining Race-Based Medicine	10/29/2020
Structural Racism and the Latinx Community	10/15/2020
Chicago's Response to COVID-19	10/1/2020
Voting During the COVID-19 Pandemic	9/17/2020
Lessons NYC has learned from COVID-19	9/3/2020
Political Determinants of Health	8/20/2020
Mental Health & COVID-19	8/6/2020
Asian American & Pacific Islander Voices	7/16/2020
Moving Upstream	7/7/2020
LGBTQ Voices	6/18/2020
Root Cause & Considerations for Healthcare Professionals	6/11/2020
Police Brutality & COVID-19	6/4/2020
The Root Cause	5/28/2020
COVID-19 & Native in the Field	5/21/2020
Latinx Voices in the Field	5/14/2020
COVID-19 & the Experiences of Medical Students	5/7/2020
Strengthening the Public Health Infrastructure to Battle Crises	4/23/2020
The Experience of Physicians of Color and COVID-19	4/2/2020

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-JUN-21

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Russ Kridel, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high quality care, preventive services, medications and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2021 and Beyond: AMA's Plan to Cover the Uninsured." The current COVID-19 pandemic has led to many people losing their employer-based health insurance. This has only increased the need for significant improvements to the Affordable Care Act. We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health

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insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.

- Our AMA also is advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap — not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020 to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020 and a decision is expected before June 2021. The decision to hear the case now will avoid several years of delay while the case worked its way through the lower courts. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts point out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Medicaid FMAP to states that enact the Affordable Care Act's (ACA) Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the federal poverty line (FPL) for 2021 and 2022; and
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ACA SPECIAL ENROLLMENT PERIOD

President Biden, during his first weeks in office, opened a new ACA special enrollment period, citing an increased need for coverage during the current economic and health crises. On March 23, 2021, the Biden administration announced its decision to lengthen the ACA special enrollment period from May 15 to August 15.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018 included provisions repealing the Independent Payment Advisory Board (IPAB). Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-JUN-21

Subject: Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"

Presented by: Monique A. Spillman, MD, Chair

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1, November 2020, "Amendment to Opinion 1.2.2, 'Disruptive Behavior and Discrimination by Patients.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.2.2 – Disruptive Behavior and Discrimination by Patients'

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

Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either 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 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

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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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 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 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.

(l) 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. (I, II, VI, IX)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-JUN-21

Subject: Amendment to Opinion 8.7, "Routine Universal Immunization of Physicians"

Presented by: Monique A. Spillman, MD, Chair

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2, November 2020, "Amendment to Opinion 8.7, 'Routine Universal Immunization of Physicians.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.7 – Routine Universal Immunization of Physicians

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 have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician's patients.

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

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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. (I, II)

REPORT 4 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (June 2021)
Augmented Intelligence & the Ethics of Innovation in Medicine
(Informational)

EXECUTIVE SUMMARY

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals.

Ethically appropriate use of augmented intelligence in health care must support, not subvert, the goals and values that define medicine as a profession. Design and implementation of systems for clinical use must take account of:

- risks to privacy;
- the potential for bias to be built into models and their outputs;
- the fact that the most powerful and useful models have the capacity to evolve autonomously, outside of human observation and independent of human control; and
- the challenge of devising mechanisms to ensure appropriate oversight across multiple stakeholders.

That these challenges are well recognized is evidenced by multiple published frameworks for an "ethics of AI," and, importantly, the convergence on key principles among them—for example, Harvard University's Berkman Klein Center for Internet & Society and the High Level Expert Group on AI of the European Commission.

The introduction of AI systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to conclude that new guidance directed solely toward AI will not best serve the profession. Therefore, the Council proposes to review existing guidance in the areas of relevance to AI and to share its deliberations with the House of Delegates in this report as well future reports.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-JUN-21

Subject: Augmented Intelligence & the Ethics of Innovation in Medicine

Presented by: Monique A. Spillman, MD, Chair

AUGMENTED INTELLIGENCE & THE ETHICS OF INNOVATION IN MEDICINE

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals [1,2,3,4].

The AMA Council on Ethical and Judicial Affairs (CEJA) recognizes that AI-based tools can serve a variety of ends in health care, from supporting administrative functions and streamlining institutional operations to enhancing clinical decision making for individual patients [see, e.g., 2,5]. AI systems have strengths and weaknesses across all these areas; in the council's view, the characteristics of systems that are intended to inform diagnosis, predict a patient's clinical course, and support clinical decision making, highlight the risks AI-enabled care can pose to patients and are therefore the primary focus of the present analysis.

CHALLENGES OF AI-ENABLED HEALTH CARE

Several features distinguish the data-driven machine-learning algorithms in clinical prediction models and decision support tools from other innovations in medicine that ethics guidance must take account of: the potential for bias to be built into a model and its outputs; the fact that the most powerful and useful models are both opaque and plastic, that is, they have the capacity to evolve autonomously, outside of human observation and independent of human control. It also requires recognizing that not only do these AI systems involve multiple stakeholders, but that they also "transform the modes of interaction between different agents" [6], creating challenges for devising mechanisms to govern complex AI systems and appropriately hold multiple stakeholders accountable for the performance of those systems.

A Word About Privacy

Protecting the privacy of data subjects and the confidentiality of personal information is frequently cited as a central concern in the use of AI systems [7]. However, such risks are hardly unique to AI. They are common to all activities that collect and store personal information, especially activities that rely on data stored in central repositories—electronic health records, clinical registries, DNA databanks, or tissue banks intended for research use [see, e.g. 8]. The potential for benefit is great but risks that identifiable personal information will be inadvertently disclosed or worse, intentionally misused, are high in all activities that rely on sharing access to data sets that contain such information. For these reasons, the present analysis focuses more narrowly on other features unique to characteristic especially of predictive models and decision support tools that utilize machine-learning algorithms.

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Bias

Data-driven machine-learning algorithms are subject to the familiar problem of "garbage in, garbage out." The utility and value of such algorithms is hostage to the quality of the data on which they are trained and with which they are validated. Data drawn from electronic health records (EHRs), on which most such algorithms are currently trained, build into the model itself whatever biases already characterize the data in the record, whether statistical or social [9].

As data sets, EHRs have serious weaknesses. Insofar as they include only information from individuals who have access to the health care system in the first place, and in settings that employ electronic records, they are not representative. Information about individuals who have no or irregular access to care, or whose records exist only in paper form is not available to train or validate an algorithm. Nor are EHR data "pristine"—with rare exceptions, electronic records capture information "downstream" of human judgments, in effect training the algorithm to replicate human cognitive errors as well as any design flaws in the record system itself [9,10].

Even well-intended efforts to correct for possible bias can have unintended consequences. For example, race-adjusted assessments for clinical conditions are often based on the misconception that "race" is a reliable proxy for genetic difference and fail to recognize that "race and health reflect enmeshed social and biologic pathways" [11]. Rather than correct for inequity, these algorithms may direct resources away from patients who are members of minoritized populations and inappropriately propagate race-based medicine instead of the equitable personalized care intended [11]. Moreover, algorithms that are fair out of the box can become biased over time once implemented, affected by characteristics of the contexts, goals, and ways they are deployed [12].

Technical solutions are being explored to mitigate bias before, during, or after an algorithm processes data [9,13].

Opacity & Plasticity

The operation of a machine-learning algorithm can be opaque for any of several reasons. In some cases, this is intentional, such as interest in protecting proprietary information; in others it reflects the fact that being able to read and interpret computer code remains a specialized skill not yet widely shared. A more fundamental challenge, however, lies in understanding highly complex algorithms as they operate on data [14]. The most powerful—and useful—algorithms are "black boxes." As a machine-learning algorithm operates on data its internal decision logic "is altered as the algorithm 'learns'" [14]. Such algorithms have the capacity to evolve in ways that may be impenetrable to human understanding – even to their developers. Because the algorithm's operations "do not naturally accord with human semantic explanations," attempts to provide humanly understandable explanations are "at best incomplete and at worst falsely reassuring" [14]. In this, data-driven AI systems are qualitatively different from other innovations in medicine.

Validation

Robust validation lags the development of AI systems in health care. For example, of some 1366 cardiovascular clinical prediction models (CPM) in the Tufts PACE Clinical Prediction Model registry, fewer than 600 reported at least one validation [15]. Current practice generally assesses only a single model at a time and thus cannot provide "reliable ranking of the comparative performance of the many CPMs available for the same application," which allows a small number of models to dominate clinical practice "based on tradition and herding behavior, rather than high-quality evidence" [15]. Randomized clinical trials that assess the clinical utility of CPMs are rare.

Physicians need to be critical consumers of published reports about new AI models, and take into account not only where a report was published, but the source and size of the dataset on which the algorithm was based, whether it was tested on real clinical data, whether its performance was compared to existing solutions, whether it was evaluated for how readily it can be implemented, and whether its results were interpretable to the intended end users [5].

In response to the "current lack of best practice guidance specific to machine learning and artificial intelligence," researchers have proposed 20 key questions to address issues of transparency, reproducibility, ethics, and effectiveness in research involving machine learning and AI [16]. These questions probe issues of inception (e.g., "What is the health question relating to patient benefit"), study design ("Are the data suitable to answer the clinical question…?"), statistical methods, reproducibility, impact (e.g., "Are the results generalizable to settings beyond where the system was developed…?"), and implementation (e.g., "How is the model being regularly reassessed and updated as data quality and clinical practice changes…?").

Oversight & Accountability

Debate continues about whether or to what extent existing models for oversight of medical technologies can be adapted to provide adequate oversight of AI systems in health care. Models for human subjects protections are poorly suited to the evolving "cyber social experiment" [17] represented by machine-learning algorithms, for essentially the same reasons these protections are problematic in contexts of quality improvement activities, or other research that involves the use of personal health or genetic data or stored biological materials [8]. Nor do machine-learning algorithms fit comfortably within current paradigms for oversight of medical devices, even the Food and Drug Administration's new regulatory framework created under the 21st Century Cures Act [8,18].

Beyond regulatory oversight, the increasing complexity and power of AI systems have prompted calls for the health care organizations that deploy such systems to implement programs of "algorithmic stewardship," analogous to antimicrobial stewardship, "to ensure that algorithms are used safely, effectively, and fairly" [19]. On this model, a designated body within the institution would be tasked with creating and maintaining an inventory of the algorithms deployed within the institution and monitoring the performance of AI systems.

Importantly, inserting AI systems into the process of clinical decision making distributes agency among multiple entities—the patient, the physician, the AI system, its designers, the data set on which it was trained, the institution that deployed it—raising questions about "who is guiding clinical decision-making, in which ways, and on what grounds" [6]. This in turn

> "raises a problem of many hands for ascriptions of responsibility: since a plurality of agents contributes to decision-making guided by AI-DSS [decision support systems], it becomes less clear who is morally and legally answerable in which ways. With the involvement of autonomous, adaptive and learning systems, it becomes harder to ascribe individual responsibility and liability for singular decisions, especially those with adverse outcomes" [6].

FRAMEWORKS FOR ETHICAL AI

That these challenges are well recognized is evidenced by multiple published frameworks for an "ethics of AI," and, importantly, the convergence on key principles among them. Thus, a review prepared by Harvard University's Berkman Klein Center for Internet & Society identified the following as common themes among 36 discussions of "how AI generally *ought* to be developed,

deployed, and governed" from governmental agencies, corporations, and private sector organizations [7]:

- Privacy—data subjects have some degree of influence over how and why information about them is used
- Accountability—AI systems should be subject to appropriate oversight during development and deployment, and that appropriate remedies be provided if harm occurs
- Safety and security—AI systems should be reliable and perform as intended, and that systems are appropriately protected against external threats
- Transparency and explainability—it is clear when AI systems are being used and for what task, and that justifications for decision outputs be intelligible
- Fairness and nondiscrimination—steps are taken to prevent and mitigate against discrimination risks in the design, development and application of AI systems
- Human control of technology—important decisions remain subject to human control
- Professional responsibility—individuals and teams involved in the design, development and deployment of AI systems take responsibility for the performance and effects of those systems
- Promotion of human values—the ends to which AI systems are devoted and the means by which they are implemented should correspond with core social norms

The High Level Expert Group on AI of the European Commission identifies five fundamental ethical principles to govern the design and deployment of AI systems [20]:

- Beneficence ("do good")—AI systems should be designed and developed to improve individual and collective well-being.
- Non-maleficence ("do no harm"—By design, AI systems should protect the dignity, integrity, liberty, privacy, safety, and security of human beings … . At the very least, AI systems should not be designed in a way that enhances existing harms or creates new harms for individuals.
- Autonomy ("preserve human agency")—Autonomy of human beings in the context of AI means freedom from subordination to, or coercion by, AI systems. Human beings interacting with AI systems must keep full and effective self-determination over themselves.
- Justice ("be fair")—The principle of justice imparts that the development, use, and regulation of AI systems must be fair. Developers and implementers need to ensure that individuals and minoritized groups maintain freedom from bias, stigmatization, and discrimination.
- Explicability ("operate transparently")—Technological transparency implies that AI systems be auditable, comprehensible and intelligible by human beings at varying levels of comprehension and expertise. Business model transparency means that human beings are knowingly informed of the intention of developers and technology implementers of AI systems.

A report by the Digital Health Learning Collaborative of the National Academy of Medicine similarly identifies beneficence, non-maleficence, autonomy, and justice as fundamental principles for ethical AI in medicine [4].

MOVING FROM PRINCIPLES TO PRACTICE

Recognizing the distinctive challenges AI systems can pose and agreeing on key values and principles that should inform AI systems is essential, but is not enough to guarantee the design, development, and deployment of "ethical AI" in health care or any other domain. As a report by the Gradient Institute has observed, AI systems "possess no intrinsic moral awareness or social context with which to understand the consequences of their actions. To build ethical AI systems, designers must meet the technical challenge of explicitly integrating moral considerations into the objectives, data and constraints that govern how AI systems make decisions" [21].

Algorithms consider only the objectives and constraints supplied by their designers. To embed fundamental ethical considerations into AI systems requires that governing ethical objectives and constraints—for example, "fairness"—be expressed mathematically, as "precise, measurable quantities." For an algorithm to approximate the ethical reasoning a human would bring to bear in making a given decision, its designers must also specify acceptable balances among competing objectives [21]. Further, as some researchers have noted, "analyses of algorithmic fairness in healthcare lack the contextual grounding and causal awareness necessary to reason about the mechanisms that lead to health disparities, as well as about the potential of algorithmic fairness methods to counteract those mechanisms" [22].

Moreover, AI systems must be designed so that the consequences of a system's actions "align with the ethical intent motivating the deployment of the system" [21]. That is, systems must not only be designed in ways that account for bias in training data, but in ways that enable them to apply causal reasoning to model the consequences of its actions and assess the relative likelihood of those consequences occurring. Mathematically representing the kind of multidisciplinary expertise and sensitivity to context that characterize human moral is extremely difficult.

Given these realities, human oversight of AI systems is essential. If overseers are to be able to "anticipate, detect, and correct problems," an AI system must be transparent and interpretable. To reduce the risk that an AI system "will be motivated, designed, or operated in a socially unacceptable way," decisions first must be made about what information needs to be made transparent to whom. The system must further be interpretable in ways that enable people "to understand [a system's] reasoning processes, explain how mistakes occurred, or inform users how to adapt their behavior to obtain different decisions from systems in the future" [21]. Yet, like "fairness," interpretability, often comes at the cost of accuracy, and "determining what attainable compromise between predictive power and effective human oversight results in the best ethical outcomes" will remain a challenge for the foreseeable future.

Finally, Gradient's analysis proposes, oversight and accountability for ethical AI should be sensitive to the complex nature of AI systems and to the multiple contexts in which those systems are used, noting that "labelling requirements, special taxation or regulatory approval processes for 'AI systems' broadly construed" are "unlikely to be helpful" [21]. They propose, instead, sector-specific oversight of the contexts in which AI systems are applied, to permit evidence-based, technically informed regulation that is able to keep pace with rapid, ongoing evolution in the technology.

GUIDANCE IN THE AMA CODE OF MEDICAL ETHICS

The *AMA Code of Medical Ethics* defines fidelity to patients and physicians' corresponding responsibility to promote patients' well-being as the core value of medicine as a profession. Opinion 1.1.1, "Patient-Physician Relationships," holds that

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for patients' welfare.

Innovations in health care should sustain this fundamental commitment of fidelity to patients. Those who design and deploy new interventions or technologies, particularly interventions or technologies intended to directly interface with decisions about patient care, have a responsibility to ensure that their work serves the goals of medicine as a priority. Thus Opinion 1.2.11, "Ethically sound innovation in medical practice," provides that any given innovation must be scientifically well grounded and focus on the interests of patients, not those of innovators or health care institutions.

Guidance in Opinion 1.2.11 further recognizes that introducing new technologies or other innovation into medical practice poses challenges at the systemic level as well as for individual physicians. Strong practice requires attention not only to individual clinical interactions "at the bedside," but equally to the organizational policies, practices, and infrastructure of health care institutions that deploy a medical innovation. Innovators have a responsibility to engage stakeholders early in the process and must consciously design innovations to minimize risks to individual patients and maximize the likelihood they will be adopted and will benefit populations of patients. Innovators also have an ethical obligation to be sensitive to the cost implications of innovation and aware of influences that may drive the creation and adoption of innovations for reasons other than patient or public benefit. Institutions and physician practices that adopt innovations have a responsibility to ensure that appropriate infrastructure is in place to support effective implementation and oversight.

Guidance in Opinion 11.2.1,"Professionalism in Health Care Systems," sets out the responsibilities of physician-leaders to create conditions that support physician professionalism within their organizations, including responsibilities to ensure that institutional arrangements that govern care are transparent and that decisions reflect input from key stakeholders. It defines leaders' responsibilities to ensure that mechanisms adopted to influence physician decision making are "designed in keeping with sound principles and solid scientific evidence," deployed fairly so that they "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities." It further holds physician-leaders responsible to ensure the institution provides avenues "for meaningful appeal and advocacy on behalf of patients" and for monitoring deployment of new practices and tools to identify and respond to their effects on patient care.

ASKING THE RIGHT QUESTIONS

The majority of physicians will be consumers of AI systems developed by others—including even those physicians who are affiliated with institutions that are actively engaged in developing AI for health care. As individual end users, physicians cannot reasonably be expected to have the requisite skills or opportunity to evaluate AI systems, and should not be, any more than they are expected to make firsthand assessment of other diagnostic or therapeutic innovations. They must rely on their institutions—or the vendors from whom they purchase AI systems for their practices—to ensure that those systems are trustworthy.

Ethically appropriate use of AI in health care must support, not subvert, the goals and values that define medicine as a profession. Physicians should be thoughtful consumers of AI and recognize

that they have a responsibility to use their voice as professionals and their knowledge of their patients' needs to help inform decisions about what AI systems will be implemented in the care settings in which they practice. They should be able to expect that health care institutions with which they are affiliated can answer the following questions when deploying an AI system that will affect clinical practice:

- What recognized clinical need among our patient population is this tool intended to address?
- Has it been rigorously demonstrated to successfully meet that need among patients relevantly similar to ours in comparable clinical settings?
    - By whom?
- What is the worst that could happen to the person who is most adversely affected if we deploy this system?
    - Are those who are most likely to be adversely affected already disadvantaged compared to others?
    - How will the institution minimize the possibility of a "worst case" scenario occurring?
- Through what process and by whom was the decision made to acquire and deploy this technology at this time?
- What resources, in both personnel and infrastructure, are needed to deploy this technology successfully?
    - How will the institution ensure that these resources are available?
- How will the institution monitor the performance of this system once it is deployed?
    - Are there clear protocols for clinicians to contribute to performance assessment? To regularly receive information about the system's impact on patient care/outcomes?
- How will the institution support my exercise of professional clinical judgment and expertise with respect to clinical predictions or treatment recommendations generated by this AI system?

CONCLUSION

As the foregoing analysis indicates, the introduction of augmented intelligence systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to conclude that new guidance directed solely toward AI will not best serve the profession. Therefore, the Council proposes to review existing guidance in the areas of relevance to AI and to share its deliberations with the House of Delegates in future reports.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-JUN-21

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Monique A. Spillman, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

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APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2020 – MARCH 31, 2021

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
10	Determinations of no probable cause
22	Determinations following a plenary hearing
7	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
10	No sanction or other type of action
5	Monitoring
6	Probation
1	Revocation
7	Suspension
1	Denied
1	Suspension lifted
3	Censure
2	Reprimand
3	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
6	Members placed on Probation/Monitoring during reporting interval
6	Members placed on Probation without reporting to Data Bank
6	Probation/Monitoring concluded satisfactorily during reporting interval
1	Memberships suspended due to non-compliance with the terms of probation
48	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
18	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-JUN-21

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Shannon P. Pryor, MD, Chair

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD, pursuant to AMA Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

> (1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.

This report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, "Diversity of AMA Delegations," which states that, "Our AMA encourages…state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity..." and AMA Policy G-610.010, "Nominations," which states in part:

> Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity…

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

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DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2020 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2020 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2020 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for slightly over one-fifth of AMA members (21.8%) and the total U.S. physician population (22.7%), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership"; the following observations refer to changes since CLRPD Report 1-A-19. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2018 and year-end 2020, AMA membership increased by 21,402 members, an 8.6% increase.

- Younger age groups saw increases in representation among the delegates to the HOD, with the percentage of delegates under age 40 increasing from 14.1% in 2018 to 16.2% in 2020, and delegates age 40-49 increasing from 10.4% to 13.3%. Concurrent with these increases, the percentage of delegates age 50-59 decreased from 22.2% in 2018 to 18.8% in 2020, while the percentage of delegates age 60-69 decreased from 34.5% to 32.2%.

- An increase was also observed among alternate delegates under age 40, from 22.7% in 2018 to 28.5% in 2020. The percentage of alternate delegates age 60-69 decreased from 26.2% to 22.7% during the same period.

- An increase was observed among female delegates, alternate delegates, and AMA members. The percentage of female members of the AMA increased from 35.7% to 38.0% from 2018 to 2020. During the same period, the percentage of female delegates to the HOD

increased from 26.4% to 30.7%, and the percentage of female alternate delegates increased from 33.2% to 38.3%.

- Increased percentages were observed among Asian/Asian American delegates, alternate delegates and CSSG from 2018 to 2020. During that time, the percentage of Asian/Asian American delegates increased from 9.1% to 11.5%, alternate delegates increased from 13.5% to 15.9%, and CSSG increased from 15.3% to 19.9%. Simultaneous decreases were observed among white, non-Hispanic alternate delegates (from 66.6% to 63.4%) and CSSG (from 59.4% to 55.4%).

Table 1. Basic Demographic Characteristics of AMA Leadership, December 2020

	Delegates[2]	Alternate Delegates[2]	Board of Trustees[3]	Councils and Leadership of Sections and Special Groups[4]	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Mean age (years)[5]	56.8	50.2	55.8	52.5	47.0	52.6
Age Distribution						
Under age 40	16.2%↑	28.5%↑	10.0%	27.7%↓	51.3%	29.3%
40-49 years	13.3%↑	18.1%	15.0%	16.3%↑	10.8%	18.0%
50-59 years	18.8%↓	22.4%	30.0%	15.7%	9.9%	16.9%
60-69 years	32.2%↓	22.7%↓	40.0%	25.9%	10.3%	16.8%
70 or more	19.5%	8.3%	5.0%	14.5%	17.7%	19.0%
Gender						
Male	69.2%↓	61.7%↓	65.0%	52.4%	61.4%↓	63.8%
Female	30.7%↑	38.3%↑	35.0%	47.6%	38.0%↑	35.5%
Unknown	0.1%	0.0%	0.0%	0.0%	0.6%	0.7%
Race/Ethnicity						
White non-Hispanic	68.3%	63.4%↓	60.0%	55.4%↓	49.9%↓	50.1%
Black non-Hispanic	4.6%	5.0%	15.0%	7.2%	5.0%	4.3%
Hispanic	3.1%	3.1%	0.0%	4.8%	6.0%	5.7%
Asian/Asian American	11.5%↑	15.9%↑	10.0%	19.9%↑	15.5%	15.4%
Native American	0.1%	0.2%	0.0%	0.0%	0.4%	0.3%
Other[6]	1.3%	2.2%	0.0%	1.2%	1.4%	1.4%
Unknown	11.0%	10.2%	15.0%	11.4%	21.8%	22.7%
Education						
US or Canada	92.0%	92.2%	100.0%	86.7%↑	82.4%	77.6%
IMG	8.0%	7.8%	0.0%	13.3%	17.6%	22.4%

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.

Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.

- The life stage, employment, and specialty characteristics of delegates to the HOD saw few changes from 2018 to 2020, with decreases observed among established physicians (from 49.8% in 2018 to 45.8% in 2020) and self-employed solo practice physicians (from 15.0% to 13.0%).

- Among alternate delegates, increased proportional representation was observed among students (6.2% to 9.4%) and residents (5.7% to 8.5%), while decreases were observed among established physicians (52.4% to 49.7%) and senior physicians (21.9% to 19.4%). The percentage of alternate delegates employed in group practice settings (39.9% to 37.7%), state or local government hospitals (11.5% to 8.7%) and medical schools (11.5% to 8.7%) declined, as did physicians whose self-designated specialty was surgery (20.4% to 17.9%) and other (17.7% to 15.0%).

- Among CSSG, the percentages of students (11.8% to 8.4%) and young physicians (15.9% to 9.6%) decreased, while the percentage of established physicians increased from 34.1% to 41.0%. Decreases in representation were also observed among physicians working in self-employed solo practice (12.4% to 10.2%) and medical schools (8.8% to 5.4%), while representation of physicians in group practices increased from 27.6% to 33.7%. Among specialties, increases were observed in family medicine (6.5% to 9.6%), internal medicine (14.7% to 18.7%), and obstetrics and gynecology (9.4% to 13.3%), and decreases were observed in surgery (19.4% to 16.9%) and psychiatry (8.2% to 6.0%).

Table 2. Life Stage, Present Employment and Self-Designated Specialty1 of AMA Leadership, December 2020

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Life Stage						
Student[2]	4.8%	9.4%↑	5.0%	8.4%↓	21.0%	7.9%
Resident[2]	6.1%	8.5%↑	5.0%	12.0%	24.5%	9.9%
Young (Under age 40 or first eight years of practice) ^	7.0%	13.1%	0.0%	9.6%↓	9.6%	15.7%
Established (Age 40-64) ^	45.8%↓	49.7%↓	60.0%	41.0%↑	22.1%	39.3%
Senior (Age 65 or more)^	36.4%	19.4%↓	30.0%	28.9%	22.8%	27.2%
Present Employment						
Self-employed solo practice	13.0%↓	9.6%	20.0%	10.2%↓	6.7%	8.3%
Two physician practice	1.5%	2.0%	10.0%	1.8%	1.4%	1.8%
Group practice	41.7%	37.7%↓	40.0%	33.7%↑	24.0%	40.2%
Non-government hospital	6.1%	6.5%	5.0%	4.2%	3.1%	4.3%
State or local government hospital	10.3%	8.7%↓	5.0%	10.8%	3.9%	6.3%
HMO	0.7%	1.3%	0.0%	0.6%	0.2%	0.2%

^ Reflects section/group definition of its membership.

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Medical School	3.7%	2.8%↓	10.0%	5.4%↓	1.0%	1.5%
U.S. Government	3.3%	4.1%	0.0%	2.4%	0.9%	1.7%
Locum Tenens	0.4%	0.0%	0.0%	0.0%	0.2%	0.2%
Retired/Inactive	6.9%	5.7%	0.0%	8.4%	11.1%	12.1%
Resident/Intern/Fellow	6.1%	8.5%↑	5.0%	12.0%	24.5%	9.9%
Student	4.8%	9.4%↑	5.0%	8.4%↓	21.0%	7.9%
Other/Unknown	1.5%	3.7%	0.0%	1.8%	1.9%	5.7%
Self-designated specialty[3]						
Family Medicine	10.6%	10.0%	5.0%	9.6%↑	8.5%	11.4%
Internal Medicine	22.7%	19.2%	30.0%	18.7%↑	19.7%	22.7%
Surgery	22.1%	17.9%↓	40.0%	16.9%↓	13.4%	13.4%
Pediatrics	3.3%	5.2%	0.0%	5.4%	5.2%	8.7%
OB/GYN	6.6%	6.1%	5.0%	13.3%↑	5.0%	4.6%
Radiology	5.4%	5.7%	0.0%	4.2%	3.5%	4.5%
Psychiatry	4.2%	4.4%	5.0%	6.0%↓	4.2%	5.2%
Anesthesiology	3.4%	3.9%	5.0%	3.6%	3.9%	5.0%
Pathology	1.9%	3.3%	0.0%	0.0%	1.8%	2.2%
Other specialty	15.2%	15.0%↓	5.0%	13.9%	13.9%	14.4%
Student	4.8%	9.4%	5.0%	8.4%↓	21.0%	8.0%

[2] Students and residents are so categorized without regard to age.
[3] See Appendix B for a listing of specialty classifications.

For further data, including information on state medical associations and national medical specialty societies, please see Appendix A.

PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on initiatives they have instituted to encourage diversity among their delegations, and the outcomes of these initiatives.

- Nominating committees: As has been noted in previous editions of this report, nominating committees act as a primary mechanism with which delegations attempt to promote diversity among their leadership and AMA representatives. Associations noted that their nominating committees are encouraged to consider the demographic makeup of their members, as well as those of leadership, including boards of trustees, delegations, etc. In addition to demographic characteristics previously listed, other elements of diversity considered by nominating committees included specialty, practice setting and geographic region.

- Task forces and committees on diversity, equity, and inclusion: An increasing number of associations have formed task forces and/or committees with the goals of increasing and promoting diversity, equity, and inclusion among their ranks. Among the goals of such groups are to develop strategies to encourage cultures of diversity, equity and inclusion across membership, leadership and educational activities; identify specific and actionable steps to advocate for and foster diverse and inclusive environments within their

associations and representatives to other organizations such as the AMA; review diversity and inclusion among their boards of trustees, committee chairs, committee members, annual meeting program participants, presenters and award recipients; and develop initiatives to ensure open access to leadership positions and other opportunities throughout their organizations. Associations that have implemented task forces and committees have noted that they have implemented many or all of the groups' recommendations, and that the efforts have led to increased diversity among their leaderships.

- Improved data collection: Several associations noted the need for baseline data to measure the effectiveness of diversity and inclusion initiatives and undertook efforts to collect necessary data. Such efforts included evaluating and updating questions in membership surveys, automated diversity data collection from volunteers for workgroups and representative positions, and the development of dashboards and other reporting mechanisms that help understand the demographic makeup of the various groups and representative positions within their associations. Lack of adequate demographic data, as well as hesitance to request data that some individuals may be uncomfortable providing, was routinely cited as a barrier to implementing and measuring the efficacy of diversity, equity, and inclusion initiatives.

- Educational and outreach efforts: Associations mentioned a variety of events and initiatives aimed to educate their members and the public on diversity and inclusion, as well as outreach efforts to demonstrate the value of associations to more diverse populations. Among those efforts were town halls on race, equality, and justice; social media campaigns featuring issues related to physician diversity, underserved communities, and disparities; expanding educational opportunities for students from underrepresented social groups at the undergraduate and graduate levels; implementation of a "diversity day" as part of annual awareness events (e.g., National Physicians Week); and collaborating with professional associations with similar foci to increase awareness of their efforts to underrepresented social groups. These efforts demonstrate that attempts to increase diversity among leadership within associations can also include efforts to recruit members from more diverse social groups to participate as members, which in turn lead to more diverse and representative leaders.

- Efforts to advance younger members: Delegations have made efforts to encourage more participation by previously underrepresented groups, particularly by engaging residents, medical students, and young physicians as active participants in delegation activities, including as delegates. The groups expressed hope that these younger members would continue participation in the future and participate as members of specialty and state delegations. These associations noted that in addition to increasing age diversity among leadership, younger members tend to be more diverse in terms of other demographic characteristics.

CLRPD hopes that these initiatives may act as useful examples for those societies considering strategies by which to promote diversity among their own memberships and leaders.

For raw counts of the above tables, as well as detailed state and specialty society data, please see the appendices.

APPENDIX A

Table 3. Basic Demographic Characteristics of AMA Leadership

	Delegates[2]	Alternate Delegates[2]	Board of Trustees[3]	Councils and Leadership of Sections and Special Groups[4]	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Mean age (years)[5]	56.8	50.2	55.8	52.5	47.0	52.6
Age Distribution						
Under age 40	109	131	2	46	139,355	407,345
40-49 years	89	83	3	27	29,271	250,268
50-59 years	126	103	6	26	26,992	235,857
60-69 years	216	104	8	43	28,081	233,980
70 or more	131	38	1	24	47,956	264,140
Gender						
Male	464	283	13	87	166,793	887,425
Female	206	176	7	79	103,274	494,657
Unknown	1	0	0	0	1,588	9,508
Race/Ethnicity						
White non-Hispanic	458	291	12	92	135,523	697,801
Black non-Hispanic	31	23	3	12	13,562	59,965
Hispanic	21	14	0	8	16,394	78,855
Asian/Asian American	77	73	2	33	42,101	214,602
Native American	1	1	0	0	974	3,764
Other[6]	9	10	0	2	3,804	20,031
Unknown	74	47	3	19	59,297	316,572
Education						
US or Canada	617	423	20	144	223,820	1,079,301
IMG	54	36	0	22	47,835	312,289

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Life Stage						
Student[2]	32	43	1	14	56,959	110,305
Resident[2]	41	39	1	20	66,648	137,332
Young (Under age 40 or first eight years of practice) ^	47	60	0	16	26,156	217,953
Established (Age 40-64) ^	307	228	12	68	60,070	547,156
Senior (Age 65 or more)^	244	89	6	48	61,822	378,844
Present Employment						
Self-employed solo practice	87	44	4	17	18,275	114,866
Two physician practice	10	9	2	3	3,822	24,890
Group practice	280	173	8	56	65,113	558,755
Non-government hospital	41	30	1	7	8,478	59,952
State or local government hospital	69	40	1	18	10,605	87,872
HMO	5	6	0	1	613	2,301
Medical School	25	13	2	9	2,743	20,951
U.S. Government	22	19	0	4	2,508	24,069
Locum Tenens	3	0	0	0	430	2,786
Retired/Inactive	46	26	0	14	30,228	168,331
Resident/Intern/Fellow	41	39	1	20	66,648	137,332
Student	32	43	1	14	56,959	110,305
Other/Unknown	10	17	0	3	5,233	79,180
Self-designated specialty[3]						
Family Medicine	71	46	1	16	23,140	158,727
Internal Medicine	152	88	6	31	53,524	316,032
Surgery	148	82	8	28	36,344	186,535
Pediatrics	22	24	0	9	14,203	120,915
OB/GYN	44	28	1	22	13,636	64,059
Radiology	36	26	0	7	9,558	62,156
Psychiatry	28	20	1	10	11,301	72,180
Anesthesiology	23	18	1	6	10,521	69,030
Pathology	13	15	0	0	4,754	30,997
Other specialty	102	69	1	23	37,676	200,103
Student	32	43	1	14	56,998	110,856

[2] Students and residents are so categorized without regard to age.
[3] See Appendix B for a listing of specialty classifications.

^ Reflects section/group definition of its membership.

Table 5. Characteristics of Specialty Society Delegations[1]

	Mean Age	% Female	% IMG	% Resident
AMA Members (n =271,655)	47.0	38.0%	17.6%	24.5%
Specialty Society Delegates and Alternates (n =452)	54.4	35.0%	6.9%	4.0%
Family Medicine Delegations (n =31)	53.4	38.7%	9.7%	6.5%
Internal Medicine Delegations (n =100)	54.5	35.0%	11.0%	7.0%
Surgery Delegations (n =101)	57.6	15.8%	5.0%	1.0%
Pediatrics Delegations (n =14)	54.5	78.6%	0.0%	7.1%
OB/GYN Delegations (n =26)	57.3	65.4%	3.8%	0.0%
Radiology Delegations (n = 34)	53.7	29.4%	5.9%	8.8%
Psychiatry Delegations (n =23)	52.7	39.1%	4.3%	0.0%
Anesthesiology Delegations (n =16)	54.1	31.3%	12.5%	0.0%
Pathology Delegations (n =22)	53.7	36.4%	9.1%	0.0%
Other specialty Delegations (n =85)	51.2	41.2%	4.7%	4.7%

[1] See Appendix B for a listing of specialty classifications.

Table 6. Mean Age of AMA Members and Delegations by State

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	2,988	51.4	8	61.8
Alaska	368	55.2	3	*
Arizona	4,473	54.4	11	61.5
Arkansas	2,036	52.2	5	61.4
California	31,805	54.6	60	53.9
Colorado	4,306	52.7	9	55.6
Connecticut	3,246	52.9	8	67.4
Delaware	610	55.6	2	*
District of Columbia	2,020	45.6	4	55.3
Florida	15,328	55.9	31	59.3
Georgia	5,811	52.1	11	60.5
Guam	25	58.5	1	*
Hawaii	1,086	56.0	3	*
Idaho	602	55.8	2	*
Illinois	11,391	51.4	23	60.5
Indiana	4,826	51.8	10	60.2
Iowa	3,233	52.0	7	53.0
Kansas	1,834	52.5	7	63.7
Kentucky	3,797	51.3	11	57.6
Louisiana	5,597	49.9	8	53.8
Maine	1,237	54.3	3	*
Maryland	5,330	53.8	10	54.6
Massachusetts	12,209	50.7	20	56.5
Michigan	12,013	50.2	27	56.4
Minnesota	4,708	52.1	11	62.0
Mississippi	2,357	52.0	6	54.8
Missouri	5,187	48.4	10	60.2
Montana	705	56.3	2	*
Nebraska	1,736	48.7	4	49.0
Nevada	1,523	53.6	5	70.2
New Hampshire	871	54.3	2	*
New Jersey	7,934	54.4	17	64.3
New Mexico	1,112	55.3	4	58.0
New York	20,229	52.0	35	60.6
North Carolina	5,140	51.9	8	59.8
North Dakota	780	50.1	1	*
Ohio	10,697	50.6	22	53.4
Oklahoma	3,501	52.3	8	65.0
Oregon	2,385	54.3	5	59.2
Other	1,140	62.4	N/A	N/A
Pennsylvania	12,136	51.4	27	58.1
Puerto Rico	1,523	54.9	2	*
Rhode Island	985	50.4	5	59.0
South Carolina	4,111	51.3	10	61.5

* To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
South Dakota	985	51.5	3	*
Tennessee	4,804	52.0	9	62.9
Texas	20,342	50.5	31	61.5
Utah	1,785	51.6	4	61.5
Vermont	424	52.8	2	*
Virgin Islands	33	64.8	0	N/A
Virginia	7,495	52.9	14	62.9
Washington	4,295	54.3	9	53.2
West Virginia	1,837	50.8	4	67.5
Wisconsin	4,511	52.4	9	63.2
Wyoming	213	58.2	2	*
TOTAL	271,655	53.1	555	59.1

Table 7. Women and International Medical Graduates on State Association Delegations

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	2,988	8	29.5%	0	11.5%	0
Alaska	368	3	37.2%	2	8.4%	0
Arizona	4,473	11	35.2%	2	15.0%	0
Arkansas	2,036	5	36.0%	1	12.1%	1
California	31,805	60	39.9%	15	17.8%	2
Colorado	4,306	9	40.2%	6	5.5%	0
Connecticut	3,246	8	39.6%	3	19.9%	1
Delaware	610	2	31.1%	2	22.1%	0
District of Columbia	2,020	4	50.4%	0	11.8%	0
Florida	15,328	31	33.3%	8	26.2%	4
Georgia	5,811	11	39.2%	2	16.6%	1
Guam	25	1	16.0%	0	44.0%	0
Hawaii	1,086	3	35.5%	1	12.8%	0
Idaho	602	2	23.3%	1	5.3%	0
Illinois	11,391	23	38.0%	7	23.0%	6
Indiana	4,826	10	33.2%	3	14.7%	2
Iowa	3,233	7	35.2%	2	18.1%	0
Kansas	1,834	7	30.8%	3	14.6%	1
Kentucky	3,797	11	35.4%	2	14.1%	0
Louisiana	5,597	8	40.8%	2	14.3%	1
Maine	1,237	3	43.9%	1	8.8%	0
Maryland	5,330	10	42.8%	6	22.0%	4
Massachusetts	12,209	20	46.6%	6	15.4%	1
Michigan	12,013	27	37.1%	8	20.4%	4
Minnesota	4,708	11	37.8%	4	12.6%	0
Mississippi	2,357	6	31.3%	3	7.7%	0
Missouri	5,187	10	36.8%	3	10.7%	2
Montana	705	2	38.6%	1	4.1%	0
Nebraska	1,736	4	38.0%	2	7.5%	0
Nevada	1,523	5	35.3%	1	17.5%	2
New Hampshire	871	2	35.2%	0	17.5%	0
New Jersey	7,934	17	36.9%	5	28.7%	3
New Mexico	1,112	4	37.9%	1	15.2%	0
New York	20,229	35	39.7%	5	27.4%	5
North Carolina	5,140	8	34.6%	4	12.4%	0
North Dakota	780	1	37.9%	1	17.3%	0
Ohio	10,697	22	38.3%	9	16.1%	1
Oklahoma	3,501	8	33.9%	1	11.2%	1
Oregon	2,385	5	35.8%	1	7.6%	0
Other	1,140	0	25.1%	0	41.4%	0
Pennsylvania	12,136	27	36.5%	6	16.2%	3
Puerto Rico	1,523	2	42.7%	0	20.3%	1
Rhode Island	985	5	41.9%	3	15.5%	0

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	4,111	10	40.0%	1	7.3%	0
South Dakota	985	3	34.5%	1	12.2%	0
Tennessee	4,804	9	34.1%	2	11.4%	2
Texas	20,342	31	39.4%	7	17.1%	2
Utah	1,785	4	27.7%	1	5.7%	0
Vermont	424	2	39.6%	1	6.6%	0
Virgin Islands	33	0	30.3%	0	42.4%	0
Virginia	7,495	14	41.2%	4	15.8%	1
Washington	4,295	9	36.8%	3	12.9%	1
West Virginia	1,837	4	36.1%	0	21.6%	0
Wisconsin	4,511	9	36.3%	3	16.0%	1
Wyoming	213	2	26.8%	0	10.3%	0
TOTAL	271,655	555	36.1%	156	16.0%	53

American Medical Association Councils, Sections and Special Groups

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section[2]
- Resident and Fellow Section
- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

[2] The Private Practice Physicians Section was established during the Special Meeting of the House of Delegates in November 2020. Data for section leaders was therefore not included in this report.

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT OF THE SPEAKERS

Speakers' Report 1-JUN-21

Subject: Recommendations for Policy Reconciliation

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at recent meetings of the House of Delegates. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough.

RECOMMENDED RECONCILIATIONS

Policies to be rescinded in their entirety

The following directives will be rescinded in full, as the requested activity has been completed, with reports presented to the House of Delegates when required.

- D-65.988, "TIME'S UP Healthcare"
  Our AMA will evaluate the TIME'S UP Healthcare program and consider participation as a TIME'S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine with report back at the 2019 Interim Meeting.

  Board of Trustees Report 16-I-19 provided the report, which concluded that "your Board of Trustees will work with the leadership of TIME'S UP Healthcare to specify the terms of a formal partnership that will enable our organizations to work together to advance gender equity in medicine." The policy will be rescinded.

- D-165.936, "Updated Study on Health Care Payment Models"
  Our AMA will research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and international experiences.

  The Council on Medical Service authored Report 2-A-17, "Health Care Financing Models," fulfilling this directive, which will be rescinded.

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- D-215.989, "Studying Hospital Incentives for Admission, Testing and Procedures"
  Our AMA will study the extent to which US hospitals interfere in physicians' independent exercise of medical judgment, including but not limited to the use of incentives for admissions, testing, and procedures.

  This policy will be rescinded, having been studied in Council on Medical Service Report 5-A-15, "Hospital Incentives for Admission, Testing and Procedures."

- D-230.984, "Hospital Closures and Physician Credentialing"
  1. Our AMA will develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. 2. Our AMA will: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations, including tracking hospital closures, as well as how and where these closed hospitals are storing physician credentialing information; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information, and report back to the House of Delegates at the 2019 Interim Meeting.

  The model legislation called for in paragraph 1 has been prepared and is available from the Advocacy Resource Center, and your Board of Trustees presented Report 13-I-19 in fulfillment of paragraph 2 of the policy. The policy will be rescinded.

- D-285.964, "Physician Payment by Medicare"
  Our AMA will study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice.

  This should be rescinded as the study was accomplished with Council on Medical Service Report 2-A-15, "Physician Payment by Medicare."

- D-305.954, "For-Profit Medical Schools or Colleges"
  Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.

  This policy will be rescinded as the Council on Medical Education issued Report 1-I-19 in fulfillment of this directive.

- D-410.991, "Re-establishment of National Guideline Clearinghouse"
  Our AMA will research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates.

  The Board of Trustees presented report 11-I-19 in fulfillment of this request. The policy will be rescinded.

Policies to be rescinded in part

- H-85.952, "Advance Directives During Pregnancy"
  1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
  2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.
  3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
  ~~4. The Council on Ethical and Judicial Affairs will consider examining the issue of advance directives in pregnancy through an informational report.~~

  The Council on Ethical and Judicial Affairs reviewed ethics policy on advance care planning (Opinion 5.1), surrogate decision making (Opinion 2.1.2), and treatment at the end of life (Opinions 5.2, 5.3, 5.4, 5.5, and 5.6) and concluded that existing guidance is clear with respect to strong ethics practice regarding advance care planning and treatment decisions at the end of life. For this reason, Paragraph 4 of the policy will be rescinded.

- H-285.902, "Ban on Medicare Advantage "No Cause" Network Terminations"
  1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network; b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies; c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder; d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: (i) civil monetary penalties; (ii) enrollment sanctions; or (iii) incorporating the accuracy score into the Stars rating for each plan; e. ~~Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information; f.~~ Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.
  2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year; b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy; c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; d. Evaluating alternative/additional measures of adequacy.
  3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form; b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: (i) the number of contracted physicians in each specialty and county; (ii) the extent to which a plan's network exceeds minimum standards in each specialty,

subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.
7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan.

Although the VerifyHCP product still exists, our AMA is no longer a partner, and AMA is no longer offering the product. For this reason, paragraph 1(e) of the policy will be rescinded, with any necessary renumbering accomplished editorially.

- D-383.978, "Restrictive Covenants of Large Health Care Systems"
  ~~1.~~ Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.
  ~~2. Our AMA will study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.~~

  Board of Trustees Report 5-I-19 provided the study requested by paragraph 2 of the policy, so that portion of the policy will be rescinded.

Changes effected by the Speakers' Report do not reset the sunset clock for those items rescinded in part, and the changes are implemented upon filing of this report.

Fiscal Note: $500 to edit PolicyFinder