



MEMBERSHIP
MOVES
MEDICINE™

JUNE 2021

Special Meeting of the AMA House of Delegates

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

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 Numbers are deleted and not reused when policies are rescinded.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	CME – Council on Medical Education
CCB – Council on Constitution and Bylaws	CMS – Council on Medical Service
CEJA – Council on Ethical and Judicial Affairs	CSAPH – Council on Science and Public Health
CLRPD – Council on Long Range Planning and Development	

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**
 - House of Delegates Reference Committee**
- 7. Note on Order of Business**
- 8. Reference Committee Hearings**

FOLLOWING COLLATED BY REFERRAL

- 9. 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)

10. 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)

11. 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)
- 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)
- 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)
- 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)
- 401 Universal Access for Essential Public Health Services (D)
- 402 Modernization and Standardization of Public Health Surveillance Systems (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)
- 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)

**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.

TENTATIVE AGENDA (*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

1:30 pm Optional Sessions: CEJA, Scope of Practice, Litigation Center

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

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

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

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Alternate Delegate(s)

Cristina G Arriens, Edmond OK
Colin Edgerton, Sullivan's Island SC

American College of Surgeons

Delegate(s)

Anthony Atala, Winston Salem NC
Daniel Dent, San Antonio TX
Jacob Moalem, Rochester NY
Lena M. Napolitano, Ann Arbor MI
Naveen Sangji, Ann Arbor MI
Kenneth Sharp, Nashville TN
Patricia Turner, Chicago IL

Alternate Delegate(s)

David B. Hoyt, Chicago IL
Leigh A. Neumayer, Tucson AZ
Gary L. Timmerman, Sioux Falls SD

Resident and Fellow Sectional Delegate(s)

Usman Aslam, Arverne NY

American Gastroenterological Association

Delegate(s)

Claudia Gruss, Redding CT

American Geriatrics Society

Delegate(s)

Eugene Lammers, Mobile AL

Craig Rubin, Dallas TX

Resident and Fellow Sectional Delegate(s)

Kieran McAvoy, Brookfield WI

American Institute of Ultrasound in Medicine

Delegate(s)

David P. Bahner, Columbus OH

Marilyn Laughead, Scottsdale AZ

American Medical Group Association

Delegate(s)

Lynn Vaughn Mitchell, Oklahoma City OK

American Medical Women's Association

Delegate(s)

Nancy Church, Oak Lawn IL

Alternate Delegate(s)

Neelum Aggarwal, Chicago IL

American Orthopaedic Association

Delegate(s)

Norman Chutkan, Phoenix AZ

American Orthopaedic Foot and Ankle Society

Delegate(s)

Michael S. Aronow, West Hartford CT

Alternate Delegate(s)

Christopher Chiodo, Walpole MA

American Osteopathic Association

Delegate(s)

Thomas Ely, Clarksville TN

Alternate Delegate(s)

Joseph A. Giaimo, Riviera Beach FL

American Psychiatric Association

Delegate(s)

Kenneth M. Certa, Plymouth Meeting PA

Frank Alexander Clark, Simpsonville SC

Sara Coffey, Tulsa OK

Jerry L. Halverson, Oconomowoc WI

Ray Hsiao, Bellevue WA

Cheryl Hurd, Fort Worth TX

Theresa M. Miskimen, Millstone Twp NJ

Paul O'Leary, Birmingham AL

Alternate Delegate(s)

Dionne Hart, Rochester MN

Saul M. Levin, Washington DC

Ravi Navin Shah, New York NY

Resident and Fellow Sectional Delegate(s)

Karen Dionesotes, Baltimore MD

Resident and Fellow Sectional Alternate Delegate(s)

Laura Halpin, Los Angeles CA

American Rhinologic Society

Delegate(s)

Seth Brown, Farmington CT

Alternate Delegate(s)

Joshua M. Levy, Atlanta GA

American Roentgen Ray Society

Delegate(s)

Denise Collins, Detroit MI

Anton N. Hasso, Orange CA

Travis Meyer, Jacksonville FL

American Society for Clinical Pathology

Delegate(s)

Edmund R. Donoghue Jr, Pooler GA

David Lewin, Charleston SC

American Society for Clinical Pathology

Delegate(s)

James L. Wisecarver, Omaha NE

Alternate Delegate(s)

William G. Finn, Ann Arbor MI

Steven H. Kroft, Mequion WI

Jennifer Nicole Stall, Minneapolis MN

American Society for Dermatologic Surgery Association

Delegate(s)

Jessica Krant, NY

Anthony Rossi Jr, New York NY

Alternate Delegate(s)

M. Laurin Council, Saint Louis MO

Chad Prather, Baton Rouge LA

American Society for Gastrointestinal Endoscopy

Delegate(s)

Robin Mendelsohn, New York NY

Walter G. Park, Los Altos CA

American Society for Metabolic and Bariatric Surgery

Delegate(s)

John Scott, Greenville SC

Alternate Delegate(s)

Samer Mattar, Houston TX

American Society for Radiation Oncology

Delegate(s)

Shane Hopkins, Ames IA

Shilpen A. Patel, San Francisco CA

Resident and Fellow Sectional Delegate(s)

Ankit Agarwal, Chapel Hill NC

American Society for Reconstructive Microsurgery

Delegate(s)

Gregory R. Evans, Orange CA

Alternate Delegate(s)

Sean Figy, Omaha NE

American Society for Reproductive Medicine

Delegate(s)

Albert Hsu, Columbia MO

Rashmi Kudesia, Houston TX

American Society for Surgery of the Hand

Delegate(s)

David Lichtman, Ft Worth TX

Alternate Delegate(s)

Robert C. Kramer, Beaumont TX

American Society of Addiction Medicine

Delegate(s)

Stuart Gitlow, New York NY

Stephen Taylor, Vestavia AL

Alternate Delegate(s)

Kelly J Clark, Louisville KY

Seth Flagg, Silver Spring MD

American Society of Anesthesiologists

Delegate(s)

Randall M. Clark, Denver CO

James D. Grant, Bloomfield Hills MI

Ronald Harter, Dublin OH

Tripti C. Kataria, Chicago IL

Candace E. Keller, Miramar Beach FL

Michael B. Simon, Wappingers Falls NY

Gary D. Thal, Chicago IL

American Society of Anesthesiologists

Alternate Delegate(s)

Jennifer Bartlotti-Telesz, Temecula CA

Michael W Champeau, Palo Alto CA

Padma Gulur, Chapel Hill NC

Edward Mariano, Palo Alto CA

Mary Dale Peterson, Corpus Christi TX

Beverly K Philip, Boston MA

Crystal C. Wright, Houston TX

Resident and Fellow Sectional Alternate Delegate(s)

Katherine Mills, Chapel Hill NC

American Society of Breast Surgeons

Delegate(s)

David Rubin Brenin, Charlottesville VA

Steven Chen, San Diego CA

American Society of Cataract and Refractive Surgery

Delegate(s)

Parag D. Parekh, Dubois PA

American Society of Colon and Rectal Surgeons

Delegate(s)

Harry Papaconstantinou, Temple TX

Alternate Delegate(s)

Ronald Gagliano, Phoenix AZ

American Society of Cytopathology

Delegate(s)

Swati Mehrotra, Schaumburg IL

Alternate Delegate(s)

Margaret Compton, Nashville TN

American Society of Dermatopathology

Delegate(s)

Melissa Piliang, Cleveland OH

Alternate Delegate(s)

Karl Napekoski, Naperville IL

American Society of Echocardiography

Delegate(s)

Kameswari Maganti, Chicago IL

Peter S. Rahko, Madison WI

American Society of General Surgeons

Delegate(s)

Albert M. Kwan, Clovis NM

American Society of Hematology

Delegate(s)

Chancellor Donald, New Orleans LA

Kelsey Martin, Westport CT

American Society of Interventional Pain Physicians

Delegate(s)

Sachin Jha, Tustin CA

Lee Snook, Sacramento CA

Alternate Delegate(s)

Michael C. Lubrano, Boston MA

American Society of Maxillofacial Surgeons

Delegate(s)

Kant Lin, Milwaukee WI

Alternate Delegate(s)

Victor L. Lewis Jr, Chicago IL

American Society of Neuroimaging

Delegate(s)

Ryan Hakimi, Greenville SC

American Society of Neuroimaging

Alternate Delegate(s)

Marc Malkoff, Memphis TN

American Society of Neuroradiology

Delegate(s)

Jacqueline Anne Bello, New York NY

Alternate Delegate(s)

Jack Farinhas, Tampa FL

American Society of Nuclear Cardiology

Delegate(s)

Saurabh Malhotra, Lincolnwood IL

Nishant Shah, Norfolk MA

American Society of Ophthalmic Plastic and Reconstructive Surgery

Delegate(s)

Erin Shriver, Iowa City IA

American Society of Plastic Surgeons

Delegate(s)

Robert J. Havlik, WI

Lynn LC. Jeffers, Camarillo CA

Alternate Delegate(s)

Raj Ambay, Wesley Chapel FL

C. Bob Basu, Cypress TX

Resident and Fellow Sectional Alternate Delegate(s)

Aaron Kearney, Chicago IL

Danielle Rochlin, Stanford CA

American Society of Retina Specialists

Delegate(s)

Michael J. Davis, Los Angeles CA

Joe Nezgoda Jr, West Palm Beach FL

American Society of Transplant Surgeons

Delegate(s)

Thomas G. Peters, Jacksonville FL

Alternate Delegate(s)

Stuart M. Greenstein, Bronx NY

American Thoracic Society

Delegate(s)

Ajanta Patel, Chicago IL

Ai-Yui Maria Tan, Maywood IL

Chris Worsham, Charlestown MA

American Urological Association

Delegate(s)

Hans C. Arora, Cleveland OH

Terrence Robert Grimm, Lexington KY

Alternate Delegate(s)

James H. Gilbaugh, Wichita KS

Jason Jameson, Phoenix AZ

American Vein and Lymphatic Society

Delegate(s)

Christopher Pittman, Tampa FL

Alternate Delegate(s)

Vineet Mishra, San Diego CA

AMSUS The Society of Federal Health Professionals

Delegate(s)

John Cho, Fairfax VA

Army

Delegate(s)

Kent DeZee, Bethesda MD

Association for Clinical Oncology

Delegate(s)

Edward P. Balaban, Penllyn PA

Association for Clinical Oncology

Delegate(s)

Kristina Novick, Rochester NY

Ray D Page, Fort Worth TX

Alternate Delegate(s)

Steve Y. Lee, Oakland CA

Thomas A. Marsland, Petaluma CA

Erin Schwab, Grand Rapids MI

Association of University Radiologists

Delegate(s)

Stephen Chan, Closter NJ

Alternate Delegate(s)

Shyam Sabat, Gainesville FL

College of American Pathologists

Delegate(s)

James L. Caruso, Castle Rock CO

William V. Harrer, Haddonfield NJ

Jonathan Myles, Solon OH

Mark S. Synovec, Topeka KS

Alternate Delegate(s)

Jean Elizabeth Forsberg, Pineville LA

David L Gang, Springfield MA

Joseph Sanfrancesco, Charleston SC

Susan Strate, Wichita Falls TX

Congress of Neurological Surgeons

Delegate(s)

John K. Ratliff, Stanford CA

Ann R. Stroink, Bloomington IL

Alternate Delegate(s)

Maya A. Babu, Eagan MN

Endocrine Society, The

Delegate(s)

Amanda Bell, Kansas City MO

Palak U. Choksi, Ann Arbor MI

Alternate Delegate(s)

Barbara Onumah, Bowie MD

Daniel Spratt, Portland ME

GLMA: Health Professionals Advancing LGBT Equality

Delegate(s)

Jeremy Toler, New Orleans LA

Alternate Delegate(s)

Scott Nass, Sebastopol CA

Heart Rhythm Society

Delegate(s)

Jim Cheung, New York NY

Steve Hao, San Francisco CA

Alternate Delegate(s)

Timothy Larsen, Chicago IL

Infectious Diseases Society of America

Delegate(s)

Michael L. Butera, San Diego CA

Steven W. Parker, Reno NV

Alternate Delegate(s)

Nancy Crum-Cianflone, Poway CA

Resident and Fellow Sectional Delegate(s)

Megan Srinivas, Fort Dodge IA

International Academy of Independent Medical Evaluators

Delegate(s)

Gary Pushkin, Baltimore MD

International College of Surgeons-US Section

Delegate(s)

Raymond A. Dieter Jr, Glen Ellyn IL

Alternate Delegate(s)

Joshua Mammen, Leawood KS

International Society for the Advancement of Spine Surgery

Delegate(s)

Morgan P. Lorio, Nashville TN

Alternate Delegate(s)

David Polly, Minneapolis MN

International Society of Hair Restoration Surgery

Delegate(s)

Carlos J. Puig, Houston TX

Alternate Delegate(s)

Sara M Wasserbauer, Walnut Creek CA

National Association of Medical Examiners

Delegate(s)

Michelle Jorden, San Jose CA

Alternate Delegate(s)

J Scott. Denton, Bloomington IL

National Medical Association

Delegate(s)

Sandra L. Gadson, Merrillville IN

Alternate Delegate(s)

Gary Dennis, Frisco TX

Navy

Delegate(s)

James L Hancock, Fairfax VA

Alternate Delegate(s)

Joel Schofer, Chesapeake VA

North American Neuromodulation Society

Delegate(s)

Haroon I. Hameed, Washington DC

Alternate Delegate(s)

Nameer R. Haider, New Hartford NY

North American Neuro-Ophthalmology Society

Delegate(s)

Benjamin Frishberg, Carlsbad CA

Alternate Delegate(s)

Nicholas Volpe, Chicago IL

North American Spine Society

Delegate(s)

R Dale Blasier, Little Rock AR

William Mitchell, Mount Laurel NJ

Obesity Medicine Association

Delegate(s)

Ethan Lazarus, Lone Tree CO

Alternate Delegate(s)

Anthony Auriemma, Elmhurst IL

Radiological Society of North America

Delegate(s)

Michael C. Brunner, Madison WI

Kevin C. Reilly Sr, Elizabethtown KY

Laura E. Traube, San Luis Obispo CA

Alternate Delegate(s)

Shadi Abdar Esfahani, Boston MA

Nandini (Nina) M. Meyersohn, Cambridge MA

Renal Physicians Association

Delegate(s)

Louis H. Diamond, Rockville MD

Rebecca Schmidt, Morgantown WV

Society for Cardiovascular Angiography and Interventions

Delegate(s)

J. Jeffrey Marshall, Atlanta GA

Alternate Delegate(s)

Osvaldo Steven Gigliotti, Austin TX

Society for Investigative Dermatology

Delegate(s)

Daniel Bennett, Madison WI

Alternate Delegate(s)

Erica Dommasch, Boston MA

Society for Vascular Surgery

Delegate(s)

Timothy F. Kresowik, Iowa City IA

Nicolas J. Mouawad, Bay City MI

Society of American Gastrointestinal Endoscopic Surgeons

Delegate(s)

Kevin Reavis, Portland OR

Paresh Shah, New York NY

Society of Cardiovascular Computed Tomography

Delegate(s)

Dustin Thomas, Fort Wayne IN

Alternate Delegate(s)

Kanae Mukai, Salinas CA

Society of Critical Care Medicine

Delegate(s)

Russell C. Raphaely, Wilmington DE

Tina R. Shah, Atlanta GA

Alternate Delegate(s)

Kathleen Doo, Oakland CA

Josh Kayser, Philadelphia PA

Society of Hospital Medicine

Delegate(s)

Steven Deitelzweig, New Orleans LA

Brad Flansbaum, Danville PA

Ron Greeno, Los Angeles CA

Society of Interventional Radiology

Delegate(s)

Meridith Englander, Albany NY

Terence Matalon, Philadelphia PA

Alternate Delegate(s)

Stephen L Ferrara, Arlington VA

Annie K Lim, Birmingham AL

Society of Nuclear Medicine and Molecular Imaging

Delegate(s)

Gary L. Dillehay, Chicago IL

Alternate Delegate(s)

Munir Ghesani, Princeton Jct NJ

Society of Thoracic Surgeons

Delegate(s)

Jeffrey P. Gold, Omaha NE

David D. Odell, Chicago IL

Spine Intervention Society

Delegate(s)

William D. Mauck, Rochester MN

Alternate Delegate(s)

Kate Sully, Niceville FL

The Society of Laparoscopic and Robotic Surgeons

Delegate(s)

Camran Nezhat, Palo Alto CA

Triological Society, The

Delegate(s)

Michael E. Hoffer, Miami FL

Undersea and Hyperbaric Medical Society

Delegate(s)

Laurie Gesell, Brookfield WI

Alternate Delegate(s)

Helen Gelly, Marietta GA

US and Canadian Academy of Pathology

Delegate(s)

Nicole Riddle, Tampa FL

Daniel Zedek, Chapel Hill NC

Alternate Delegate(s)

Keagan H. Lee, Austin TX

Nirali M. Patel, Chicago IL

US Public Health Service

Delegate(s)

Brian M Lewis, Potomac MD

Veterans Affairs

Delegate(s)

Carolyn M. Clancy, Silver Spring MD

Academic Physicians Section

Delegate(s)

Alma B. Littles, Tallahassee FL

Alternate Delegate(s)

Suzanne M. Allen, Boise ID

Integrated Physician Practice Section

Delegate(s)

Russell C. Libby, Fairfax VA

Alternate Delegate(s)

Steven Wang, Bakersfield CA

International Medical Graduates Section

Delegate(s)

Ricardo Correa, Phoenix AZ

Alternate Delegate(s)

Sabesan Karuppiah, Overland Park KS

Medical Student Section

Delegate(s)

Pauline Huynh, Baltimore MD

Alternate Delegate(s)

Justin Magrath, New Orleans LA

Minority Affairs Section

Delegate(s)

Luis Seija, New York NY

Alternate Delegate(s)

Fatima Cody Stanford, Boston MA

Organized Medical Staff Section

Delegate(s)

Matthew Gold, Winchester MA

Alternate Delegate(s)

Nancy Fan, Wilmington DE

Private Practice Physicians Section

Delegate(s)

Timothy G. McAvoy, Waukesha WI

Resident and Fellow Section

Delegate(s)

Christopher Libby, Anaheim CA

Alternate Delegate(s)

Raymond Lorenzoni, Bronx NY

Senior Physicians Section

Delegate(s)

Louise B. Andrew, Sidney, British Columbia Ca

Alternate Delegate(s)

Thomas E. Sullivan, Beverly MA

Women Physicians Section

Delegate(s)

Josephine Nguyen, Springfield VA

Alternate Delegate(s)

Nicole L. Plenty, Katy TX

Young Physicians Section

Delegate(s)

Kavita Arora, Cleveland Heights OH

Alternate Delegate(s)

Alisha Reiss, Greenville OH

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

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

Preliminary Reference Committee Schedule

NOTE: This schedule is preliminary and subject to change depending on the volume of material to be considered in each reference committee. The order of Reference Committees D and E in particular is in flux.

Saturday, June 12, 9 a.m. to 12:30 p.m.:

- Reference Committee A
- Reference Committee F
- Reference Committee D or E

Saturday, June 12, 1 p.m. to 4:30 p.m.:

- Reference Committee B
- Reference Committee G
- Reference Committee D or E

Sunday, June 13, 9 a.m. to 12:30 p.m.:

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

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

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
- 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
- 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
- 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
- 401 Universal Access for Essential Public Health Services: not yet determined
- 402 Modernization and Standardization of Public Health Surveillance Systems: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

- 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
- 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

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

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

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

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

11
12 The task force defined the following goals specific to our stakeholders:

13 For candidates: Remove obstacles that discourage qualified individuals from seeking elected
14 positions and improve equity and transparency in the campaign.

15 For delegates: Provide ample opportunity to gain knowledge about each candidate (informed
16 electorate) without undue distraction from policy development.

17 For our AMA and our members: Ensure the best possible governance with election of the most
18 qualified candidates to lead our Association.

19
20 Election-related concerns that underlay the call to review and improve election rules fall into four
21 categories:

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

32
33 These concerns are reflected in the resolutions submitted at the 2019 Annual Meeting, which are
34 reproduced in Appendix C, in comments provided to the task force, and in survey responses
35 provided by members of the House at I-19, which are presented in Appendix D; and are further
36 discussed throughout this document (*set off by italics*). Many of our findings and recommendations
37 relate to more than one of these concerns.

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

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

7
8 Your task force struggled somewhat with gifts that are provided by certain delegations in the
9 NFOB bag seemingly every year whether or not they have a candidate. These would fall under the
10 rule for giveaways from candidates in any year in which that delegation had a candidate and a
11 candidate's name was associated with the item, and while not directly linked to a candidate in other
12 years, could be interpreted as an inducement for future candidates from that delegation. In addition,
13 the task force felt any exceptions to the rule would complicate enforcement and potentially lead to
14 a slippery slope with other delegations deciding to supply giveaways every year to remain
15 competitive. In addition, observations at the last two in-person meetings found a majority of the
16 material in the NFOB bag was left on the tables or otherwise discarded. Given the move towards
17 electronic communication and an overall desire to reduce waste, your ETF is recommending the
18 elimination of all campaign materials distributed in the NFOB bag. Although beyond our purview,
19 we believe the other materials that are included in the NFOB bag should also be discontinued or
20 distributed in other more meaningful ways. Ultimately, we believe the entire NFOB bag should be
21 eliminated.

22
23 The ETF discussed whether delegations should be allowed to provide token gifts at a reception. For
24 some delegations the gift or raffle item has become a tradition at their reception. The ETF decided
25 not to recommend prohibiting such giveaways as long as they do not include a candidate's name or
26 likeness. We recommend monitoring this to see if delegations attempt to indirectly link these gifts
27 to campaigns or use them as an inducement for a vote, in which case they could be prohibited in
28 the future.

29 30 STICKERS, BUTTONS, and PINS

31
32 Another area which may seem trivial but adds to the overall cost of a campaign with little to no
33 perceived impact on the election outcome is stickers, buttons, ribbons and pins. While they don't
34 cost much, every dollar counts. In addition to the expense, these items appear to have negative
35 appeal to a number of delegates. Your ETF heard many negative comments about "forced
36 stickering" particularly in receiving lines at receptions. Individuals said they felt pressured to
37 accept and wear stickers, even for candidates they did not support. Others responded that they wear
38 every candidate's stickers, which diminishes the value of all the stickers and clutters their badge.
39 The necessary increased security surrounding our recent meetings, including measures added to our
40 badges, pose an additional argument against stickers, and placing stickers other than on badges
41 may conflict with our enhanced behavior policies. Buttons and pins share similar negatives and
42 create holes in clothing. Finally, all of these, particularly when multiple are worn, project a less
43 than professional image to our meeting and elections. The ETF recommends that campaign
44 stickers, pins and buttons be disallowed.

45
46 Distinctly separate from the above are pins and ribbons worn to designate support of AMPAC and
47 our AMA Foundation. Pins for specialties, delegations, regions and even certain causes that do not
48 include any candidate identifier should be allowed. These should be small, not worn on the badge
49 and distributed only to members of the designated group. To prevent a "slippery slope" or
50 problems with enforcement, general distribution of any pin, button or sticker would be disallowed
51 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 not a factor 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

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

10
11 In lieu of printed material, we propose maintaining the online election manual and providing each
12 candidate the opportunity to post materials on the AMA website, within an expanded elections-
13 related set of pages (see discussion below), and the election manual would link to these pages as it
14 does to conflict of interest statements.

15 16 ELECTRONIC COMMUNICATION

17
18 The AMA rules of contact and privacy policy have been interpreted to not allow the HOD to
19 provide delegate/alternate delegate email addresses to candidates. The ETF has heard that some
20 campaigns have "harvested" email addresses from the pictorial directory and others have not. At
21 best this creates inequality and could even be seen as contrary to the spirit of AMA policy against
22 sharing email addresses. It is necessary that your Speakers and the HOD Office be able to contact
23 members of the House with confidence that the messages will not be regarded as spam; thus your
24 Speakers strive to limit our communications to essential material. At no time was this more clear
25 than leading up to the Special Meetings in the last year. Options of requiring "opting in" or "opting
26 out" so email addresses can be shared with campaigns, as some have suggested, could threaten
27 essential HOD communication. AMA corporate policies would likely be interpreted as not
28 allowing "opting in" as a default and even candidates have expressed that they believe few would
29 elect to "opt in" if required to make this choice.

30
31 For the June 2020 Special Meeting, the Speakers, upon request from the majority of candidates,
32 provided the opportunity for candidates to submit material to the HOD office which was then sent
33 electronically by the HOD in a single communication to all delegates and alternates. While this was
34 optional, every candidate took advantage of this opportunity. Parameters were established
35 regarding content, but there was considerable variability in the materials submitted, ranging from
36 resume style materials and photos to simple prose messages or endorsements. Favorable feedback
37 was received and the Speakers have continued this process for June 2021. The ETF recommends
38 continuation of this process even after return to in-person meetings.

39
40 A goal of the ETF was to create an equal opportunity for all candidates to share information
41 regarding their candidacy while also reducing the amount of unwelcomed material that delegates
42 receive. At the same time, the task force did not want to create communication rules that would be
43 difficult to track and enforce. While this recommendation does not prohibit candidates from
44 sending their own additional electronic campaign messages, campaigns are reminded that current
45 campaign rules require that any such communication must include an "unsubscribe option." Many
46 delegates expressed that electronic communications from individual candidates are unwanted and
47 may even negatively impact their view of the candidate. Given the electronic communication we
48 propose to be sent by the HOD office on behalf of all candidates it should be anticipated that
49 additional electronic communications from individual candidates would not be well received. With
50 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

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

9
10 Some delegations expressed that the stream of candidates interrupts their policy deliberations.
11 Other delegations responded that they use interview committees, made up of delegates with special
12 interest in a particular council's activities, which often meet simultaneously with candidates for
13 different races, thus lessening the time required for interviews. The task force believes this may be
14 an acceptable option for some delegations.

15
16 Consideration was given to grouping interviews together. Over the past several years the HOD
17 office has coordinated grouping section interviews together but has received negative reaction from
18 the groups preferring to have their own interviews. At the open forum and in communications since
19 there has been broad support from delegations to be allowed to continue their specific interviews.
20 While your task force believes grouping of interviews to reduce the number of interviews is
21 desirable, we believe such grouping is best done voluntarily by delegations that find they share
22 similar interests.

23
24 Others suggested that interviews be held in a format in which candidates assemble at an appointed
25 hour in front of those who are interested and questions are asked by a moderator similar to the
26 debate held when the president-elect race is contested. Concerns were raised regarding the stress
27 that would be associated with such a high stakes interview, particularly for council candidates who
28 would not typically face such a situation during council service. Others commented that these
29 interviews often result in candidates repeating or even learning from the responses of those
30 answering before them. The Specialty and Service Society holds such an interview panel, yet many
31 specialty delegations continue separate interviews. Several large delegations and even small
32 delegations confirmed that they would continue their interviews even if such a group interview
33 process was instituted, seemingly adding another round of interviews during an already packed
34 meeting rather than replacing or eliminating interviews.

35
36 Of necessity for the June 2020 Special Meeting and now again for J-21, virtual interviews have
37 been conducted by both the Speakers and individual caucuses and delegations. Given the overall
38 positive feedback received, the task force recommends continuing the option for virtual interviews,
39 including recorded interviews by the Speakers, in advance of the meeting even after we return to
40 in-person meetings. In addition, the Speakers would continue to conduct interviews with all
41 candidates to be posted on the AMA website.

42
43 Virtual interviews would be allowed during a defined period prior to the meeting in lieu of in-
44 person interviews. Caucuses could choose either method, but not both for a given race. For
45 example, a caucus may choose to conduct virtual interviews for all council races but choose to
46 conduct live interviews for all officer races. These interviews would be facilitated by the HOD
47 Office similarly to how they have been handled for the June 2020 and 2021 campaigns. Recording
48 of virtual interviews must be disclosed to candidates prior to recording and only with their consent,
49 and the recordings may only be shared with members of the interviewing caucus/group.

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

11 *Distractions and Technology*

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

18 VOTING PROCESS AND ELECTIONS SESSION

19
 20
 21
 22 Our current voting process at in-person meetings crafted by bylaws, rules, and tradition developed
 23 20 plus years ago involves casting ballots in a separate room in “voting booths” on Tuesday
 24 morning during a 75-minute voting window. Results for each race are announced in the House
 25 once they become available, typically 30-40 minutes after the House has come to order,
 26 interrupting the discussion of reference committee reports. Oftentimes, runoff voting is required
 27 and accomplished using paper ballots which are printed, distributed, collected and counted (by
 28 hand) by the election tellers, again disrupting the policy discussion. If new openings are created,
 29 new nominations, speeches, voting and possibly further runoffs all interrupt House debate. Twice
 30 in the last several years elections have extended to Wednesday morning. Voting delegates must be
 31 seated at these somewhat random moments to receive a ballot, resulting in reshuffling of delegates
 32 and alternate delegates, further disrupting the deliberations. All of this when combined with
 33 appreciation and concession speeches, consumes considerable time and detracts from policy
 34 discussion. While initial voting is secure in a private booth, runoff paper ballots are distributed in
 35 the House to credentialed delegates only, but there is little actual security in this regard as ballots
 36 are “passed down the row.”

37
 38 The original resolutions adopted by the HOD specifically called for consideration of electronic
 39 voting. In 2020, in the virtual format, all the voting was done electronically by necessity. Electronic
 40 voting was secure and effective in the virtual situation and should be acceptable in person. We are
 41 confident that voting can be done with the electronic voting devices—colloquially referred to as
 42 “clickers”—that are used in business sessions of the House. The devices are easy to use, and their
 43 security and privacy features are at least as great as current methods. Briefly described, delegates
 44 (not alternate delegates) can be issued a security card that must be inserted into the device in order
 45 to vote in elections. While all devices can be used to vote on policy matters without the card, the
 46 security card is required to cast a vote in an election. Each vote should take under a minute, results
 47 are almost instantaneous and the devices can be reset for a runoff election within a minute or two.
 48 Given the virtual nature of the June 21 HOD meeting, election voting will again be electronic.
 49 Accordingly, the ETF recommends that electronic voting should be continued when we return to
 50 in-person elections at the 2022 Annual Meeting. We believe this change will simplify voting, allow
 51 results of each race including runoffs to be known before ballots are cast for the next position and

1 facilitate a new method of handling positions that were unscheduled but created by a prior election
2 result, henceforth "newly opened positions" (see Newly Opened Positions below).
3

4 To further reduce the interruption of policy discussion, our Speakers have scheduled a specific
5 "Election Session" on the agenda for the June 21 HOD meeting. All election activity (except for
6 those unopposed candidates elected by acclamation at the time of nominations) including voting,
7 runoffs and speeches will occur at a scheduled time on Tuesday morning (see discussion on "the
8 day of elections") separate from policymaking sessions. The House deliberation of reference
9 committee reports will resume at a "time certain" to be specified. Delegates only will be voting at
10 this time, but alternates and guests are welcome to observe. The ETF recommends continuing this
11 scheduling once in-person meetings resume.
12

13 Additionally, while the task force understands the tradition of thank you speeches by both the
14 victors and unsuccessful candidates, the task force nevertheless prefers that all such speeches be
15 discontinued. No one doubts the sincerity of the thank you delivered by those speaking, but those
16 words of appreciation could better be delivered privately. Moreover, sparing losing candidates the
17 discomfort, often palpable throughout the House, of appearing at a microphone shortly after
18 hearing negative results should be considered a kindness, not a slight, and allows them a graceful
19 exit. These "points of personal privilege" were not heard in June 2020 and will not occur in June
20 2021. Candidates were invited to share written comments which were subsequently sent to the
21 House. The Speakers have heard no complaints regarding this decision. Our intention is not to
22 create a rule disallowing these speeches (since no rule allowing them exists), but rather to set the
23 stage for the Speakers to use their discretion based upon the volume of business at hand and the
24 number of candidates. We encourage the Speakers to continue to collect personal points from
25 candidates and share them electronically with the House after the meeting, eliminating the need for
26 the speeches during the meeting itself. If such speeches are allowed in the future, we strongly
27 suggest that they be limited to 60 seconds.
28

29 With these proposed changes, the task force believes voting will be secure, the time consumed for
30 elections will be greatly reduced, and there will be no interruptions of policy discussion.
31

32 ANNOUNCEMENTS AND NOMINATIONS 33

34 The ETF considered various announcement/nomination scenarios with the intent of clarifying this
35 process, increasing vetting of all candidates, ameliorating the negative aspects of "pop-ups" (see
36 Newly Opened Positions below) and maintaining the time limit on active campaigning to the
37 period of April through June.
38

39 Currently candidates for all elected positions may announce their candidacy with a virtual card
40 projected at the conclusion of the Annual and/or Interim Meetings and then posted on the AMA
41 candidate website. In addition, current rules allow candidates that do not submit an announcement
42 card at these times to send an announcement to delegates even before the "active campaign" has
43 begun. As a result candidates may in effect announce their candidacy directly to delegates at any
44 time, making it difficult to stay abreast of all current candidates for a particular position.
45

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

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

3
4 We propose that the HOD office review all known candidates following the Annual and Interim
5 Meetings and at other specified announcement times to identify unscheduled seats that may
6 potentially be newly opened by election of any announced candidates and communicate this
7 information to the House along with the names of all the candidates for each position. These
8 "Official Candidate Notifications" would add transparency and alert delegations and members of
9 the possibility of unscheduled positions that may become open if certain announced candidates are
10 elected. Members interested in becoming candidates for open or potential newly opened positions
11 would be required to send a virtual announcement card to the HOD Office and complete a conflict
12 of interest (COI) form.

13
14 The AMA Board of Trustees considers applications from council candidates at its April meeting
15 and then announces the candidates shortly thereafter. Active campaigning is allowed after this
16 announcement. Currently there is no official notification and oftentimes delegates are uncertain of
17 the exact date of the BOT meeting and start of active campaigning. Therefore, at this time another
18 "Official Candidate Notification" would be sent to the HOD. This would also signal the start of the
19 active campaigning period. Subsequent "Official Announcement Dates" would be determined by
20 the Speakers.

21
22 Candidates who become aware of potential newly opened positions for any office or council could
23 notify the HOD Office at any date of their intent to join the campaign and then would be included
24 at the next official announcement and in all subsequent announcements. Presumably this would
25 occur well before nominations occur at the Opening Session of the House. All previously
26 announced candidates will continue to be included at each official announcement (i.e. those
27 announced in June will again be presented in November, April, etc.) and all who had notified the
28 HOD Office of their intent to be nominated and completed a COI would be included in any
29 campaign activity that had not yet been finalized. This modified announcement process would not
30 prohibit late entry into the campaign but provides advantages to early entries.

31
32 As discussed below, our bylaws allow for nomination "from the floor" during the Opening Session
33 of the HOD, so candidates could elect to be nominated who had not notified the HOD office of
34 their intent and who had not been included in any official announcement. While it would still be
35 possible for a new candidate to first announce at the time they are nominated from the floor at the
36 Opening Session of the House, waiting until this moment when given the opportunity to announce
37 their candidacy in advance, would seem to put that candidate at a significant disadvantage, thus
38 encouraging candidates to announce early and be vetted. The earlier the announcement, the more
39 the opportunity to participate in the campaign process, including interviews which the survey
40 identified as the most important factor in the voting decision. This proposal would allow for
41 posting of the COI at the time of announcement (likely well before election day) or at the latest at
42 the Opening Session of the House, more than two days before the election in our current schedule.

43
44 The task force carefully considered the bylaws that allow for nominations from the floor during the
45 Opening Session. This bylaw is common among associations that hold open nominations and
46 elections. Typically nominations are declared open and then closed by a motion. No doubt this
47 option complicates the campaign process and potentially creates chaos at the last moment.
48 However, nomination at the last possible minute allows for the rare case where a candidate is
49 determined to be unavailable or unacceptable to fill a position, or a late nominated candidate for
50 some reason is an overwhelming choice. While relatively rare, this has occurred, and candidates
51 waiting until this last moment have been elected. The ETF believes this option should remain and

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

3
4 During the ETF exploration of announcements and nominations we found inconsistencies in our
5 rules surrounding the concept of announcements versus nominations. These two terms seem to be
6 used interchangeably without a clear delineation between the two. For example, we could not find a
7 basis for the Board nominating council candidates in conjunction with the April Board meeting.
8 Bylaw 6.8.1 specifies that nominations for the elected councils are made by the Board or by a
9 delegate from the floor. It does not specify when the Board actually places the names of their
10 nominees into nomination. In fact, as discussed in the paragraphs above and below all nominations
11 actually occur at the Opening Session of the House. Under the current process, candidates for
12 council positions submit applications to the Board for consideration at their April meeting prior to
13 an established March 15 deadline as discussed in Policy G-610.010, "Nominations," shown below
14 [*emphasis added*]:

15
16 Policy G-610.010, Nominations

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

28
29 These "nominations" are then announced at the conclusion of the Board's April meeting at which
30 time active campaigning may begin. Policy G-610.020 which reads in item 3 [*emphasis added*]:

31
32 (3) Active campaigning for AMA elective office may not begin until the Board of Trustees,
33 after its April meeting, announces the nominees for council seats. Active campaigning includes
34 mass outreach activities directed to all or a significant portion of the members of the House of
35 Delegates and communicated by or on behalf of the candidate. If in the judgment of the
36 Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns
37 may formally begin, the Speaker shall communicate the earlier date to all known candidates;

38
39 It is our understanding that Policy G-610.020 (3) was written more to define the start of active
40 campaigning rather than to specify the timing of the nomination process. Note that this only
41 specifies the Board "announcing the nominees" for council candidates; they are actually nominated
42 by the Board at the Opening of the House. However, council candidates under our current rules
43 may "announce" their candidacy at any point, even after the March deadline, and then be
44 nominated "from the floor" by a delegate without completing an application or being considered by
45 the Board. Review of available history did not identify a single instance when the Board did not
46 "nominate" a council candidate who submitted an application. In reality the Board review of these
47 candidates, who must be AMA members, is largely perfunctory. Procedurally nominations are
48 declared open by the presiding officer, nominations are announced by the presiding officer or
49 Board chair or made from the floor by a delegate. Then a motion is accepted to close nominations
50 (typically the presiding officer will accept nominations be closed "without objection" once no
51 further nominations appear to be pending even without a formal motion and second). To eliminate

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

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

17
18 In addition, Policy G-610.020 (3) be amended by deleting the word "nominees" and inserting the
19 word "candidates" to clarify that the Board is announcing the candidates and not actually
20 nominating them.

21
22 (3) Active campaigning for AMA elective office may not begin until the Board of Trustees,
23 after its April meeting, announces the ~~nominees~~ candidates for council seats. Active
24 campaigning includes mass outreach activities directed to all or a significant portion of the
25 members of the House of Delegates and communicated by or on behalf of the candidate. If in
26 the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by
27 which campaigns may formally begin, the Speaker shall communicate the earlier date to all
28 known candidates;

29
30 The ETF believes these proposed changes to our announcement process will clarify the process
31 while maintaining the current nominations that occur at the Opening Session of the House. These
32 changes provide transparency for delegates to know the candidates for all positions and have an
33 opportunity to vet those candidates. It also allows potential candidates to learn of the opportunities
34 to run for an unscheduled position that may become newly open as a result of another pending
35 election.

36 37 NEWLY OPENED POSITIONS

38
39 Significant concern was raised regarding how to handle elections to fill previously unscheduled
40 vacancies that are created as a result of prior elections. This most often occurs when a council
41 member with an unexpired term is elected to an officer position but may also occur when a current
42 Board member with a continuing term becomes president-elect. Current bylaws prescribe that the
43 newly opened position is filled in a separate election with nominations to be held after completion
44 of election for previously known open positions. Over the past several years multiple previously
45 unannounced candidates are then nominated, all candidates give a speech before the House and
46 then voting ensues. In the past these have been called "pop-ups."

47
48 Three general concerns have been expressed regarding "pop-up:" first, these individuals are being
49 elected without the usual vetting; second, the process of new nominations and speeches before the
50 HOD delays and distracts from policy discussion; and third, the possibility of opening a seat has
51 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.

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

5
6 If there are no open positions scheduled for election in a given year for a particular council or the
7 Board, but there is the potential for a newly opened position (one or more current candidates for a
8 higher office hold an unexpired term on a council or the Board) candidates will be solicited as
9 detailed above for the potential newly opened position. These announced candidates for the
10 potential newly opened position will proceed with all campaign activities available to them from
11 the time of their announcement forward. If the potential newly opened position does not open (ie.,
12 the individual with the unexpired term is not elected to the office they sought), no election will be
13 held. In this event these candidates will have campaigned even though there ultimately was no
14 vote. The ETF considered that this may be an unnecessary burden on the candidates, but thought
15 that this campaign experience and the resulting exposure of the candidate to the House would
16 actually be beneficial to the candidate.

17
18 If the potential newly opened position does not open but there are other open positions for the same
19 council or the Board, an election will proceed for the existing open seats. Candidates will be
20 offered the opportunity to withdraw their nomination prior to the vote. This will allow candidates
21 from the same delegation to avoid potential conflicts. Conversely, all candidates may also choose
22 to continue with the election to compete for the available positions.

23
24 Following the implementation of electronic voting during a specified election session and the
25 proposed new announcement process, in the unlikely event that a prior election results in a newly
26 opened position without a nominated candidate or more positions are open than nominated
27 candidates, the unfilled position(s) would remain unfilled until the next Annual Meeting.

28
29 There is no perfect solution to the problem of newly opened positions, but the ETF believes this
30 proposal will encourage candidates to announce their candidacy early, add transparency to our
31 elections, result in more contested elections, allow delegations the opportunity to vet candidates for
32 newly opened positions, and eliminate the distraction from policy discussion that occurs with our
33 prior "pop-up" process.

34 35 APPOINTING SELECT COUNCILS

36
37 Careful consideration was given to the idea of appointing some or all of the currently elected
38 council positions. Appointment would eliminate most if not all the issues of concern heard
39 regarding elections. In addition, appointment by a nominations committee allows for careful
40 consideration of diversity and expertise needs of a council.

41
42 The concept of appointing members to councils has several precedents within our AMA. Current
43 rules provide multiple methods of selecting appointed councils (CLRPD--selected by the BOT and
44 the Speaker, COL--selected by BOT, CEJA--nominated by the President), the public member of
45 the Board is chosen by a search committee and confirmed by the HOD, and the House
46 Compensation Committee is a combined appointment by the President and the Speaker. These
47 committees function well with the members selected by the current appointment process and the
48 task force does not recommend any change in these councils.

49
50 In addition, these various methods all enjoy a plethora of candidates for each position which is in
51 contrast to the few candidates, often unopposed, that run for councils. This may reflect a desire by

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

5
6 The task force believes that all officers and most council members should continue to be elected,
7 but recommends that the Council on Constitution & Bylaws (CC&B) should be transitioned over to
8 selection by appointment. This council, perhaps more than any other council, benefits from
9 members with particular backgrounds and skill sets that are not always appreciated in our
10 campaign process. For example, during interviews candidates for CC&B are rarely asked questions
11 regarding bylaws. Over the past several elections CC&B has attracted relatively few candidates as
12 compared to other elected councils and far fewer than appointed councils.

13
14 Concern was expressed that service on a council often leads to future leadership positions and
15 appointment may have a deleterious effect on the potential of council members moving forward. A
16 review of current and recent past successful officer candidates found that there was a balance
17 between those that had previously served on elected and appointed councils, and in fact a lower
18 representation of past CC&B members.

19
20 The specific process of appointment could be determined subsequently, but the task force favors a
21 process that would include consideration by the Board of Trustees of nominated candidates with a
22 slate for each open position presented to the House of Delegates for approval. Terms, tenure and
23 role of the council would remain unchanged.

24 25 THE ROLE AND INFLUENCE OF CAUCUSES

26
27 Concerns about the role played by caucuses in the election process have been heard for many years,
28 perhaps getting louder as caucuses have grown larger. There is little question that delegations and
29 caucuses have significant influence in our elections.

30
31 These caucuses are often the source of interviews of candidates and subsequently suggest to
32 varying degrees voting for particular candidates. A small number of delegates (5%) in the HOD
33 survey responded that they felt their vote was "mandated" by their delegation and others, while still
34 a minority (15%), said they felt "strong pressure" to vote for particular candidates. Meanwhile, our
35 current guiding principles for elections, Policy G-610.021 [*emphasis added*] clearly states –

- 36
37 1. AMA delegates should: (a) avail themselves of all available background information about
38 candidates for elected positions in the AMA; (b) determine which candidates are best qualified
39 to help the AMA achieve its mission; and (c) make independent decisions about which
40 candidates to vote for .

41
42 Insofar as AMA's elections are conducted by secret ballot, the task force believes that delegates
43 ought to be able to hew closely to these principles with little fear of repercussions. Further review
44 of the survey results show that almost ⅔ of the respondents (65%) "make their own decision" with
45 or without input from their delegation or caucus. This is not meant to suggest that delegates should
46 ignore their sponsoring organization's endorsements, only that the sponsoring organization's
47 recommendations are but a single element in a delegate's decision-making armamentarium with
48 respect to elections.

49
50 Others say they are offended by "vote trading and deals" made within and between caucuses. The
51 ETF notes that our principles go on to state:

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

3
4 As such it seems rules already exist to address these issues. The ETF strongly recommends that
5 these policies be reaffirmed and that efforts should be made to make delegates more aware of these
6 principles. In addition, we recommend Principle 2 should be strengthened by adding the following:
7 “This policy applies between as well as within caucuses and delegations.”

8
9 Furthermore, we recommend addition of another principle to discourage delegations from using
10 “rank order” lists of candidates and encourage delegations to provide an opportunity for their
11 members to have an open discussion regarding candidates.

12
13 Candidates typically seek nomination and endorsement from the groups with which they associate
14 or with whom they have perceived connection. Some argue that this provides a desirable screening
15 of candidates and a way to gain support. Others see this as controlling who is allowed to become a
16 candidate and preventing some qualified individuals from entering a race. The ETF believes
17 delegations and caucuses should have autonomy in deciding whom they support as candidates, but
18 we emphasize that the goal of our elections should be to select the most qualified leaders for our
19 Association. As such we propose another additional guiding principle for election as follows:

20
21 (8) Delegations and caucuses should be a source of encouragement and assistance to qualified
22 candidates. Nomination and endorsement should be based upon selecting the most qualified
23 individuals to lead our AMA regardless of the number of positions up for election in a given
24 race. Delegations and caucuses are reminded that all potential candidates may choose to run for
25 office, with or without their endorsement and support.

26
27 In addition, the ETF believes other recommendations within this report (recorded interviews,
28 posted website materials, electronic communications originating from the HOD Office, etc.) will
29 provide candidates more opportunity independent of the assistance from well funded delegations
30 and large caucuses. Any candidate will be able to participate in the AMA reception providing them
31 exposure without the need for a separate reception. Several other recommendations should also
32 reduce the expense of campaigns, further reducing the influence of delegations and caucuses.

33
34 During the task force discussions, the question was raised about the size of caucuses. That is,
35 should the size of a caucus be capped such that its influence—whether real or perceived—does not
36 become outsized? The task force is not making a recommendation on this matter at this time. It
37 remains a question whether limitations on caucuses are within the House’s authority at all. The
38 ETF recommends continued monitoring of the effects of the adopted recommendations and
39 consideration of future changes should they be deemed necessary.

40 41 THE DAY OF THE ELECTIONS

42
43 The task force heard suggestions for moving the day of the elections to earlier in the Annual
44 Meeting, but does not favor such a change. First, determining who are the best candidates takes
45 time, and the time devoted to interviews is valued by both candidates and the electorate. An earlier
46 date would increase reliance on speeches and written materials rather than “getting to know” the
47 candidates. Truncating the vetting process would be most harmful to lesser known candidates and
48 those from smaller delegations. After examining the other days of the Annual Meeting, the ETF
49 concluded that moving the elections would cause greater disruption to the already full agenda for
50 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.

1 CONCLUSION AND RECOMMENDATIONS

2
3 Our AMA election process is guided by our bylaws, various policies adopted by the HOD, the
4 HOD Reference Manual and tradition with overall responsibility resting with the Speaker. As such,
5 the following recommendations, if adopted, will require thorough review and editing of these
6 documents to reflect the changes.

7
8 Following the detailed discussion above, the Election Task Force recommends that the following
9 recommendations be adopted, with the rules to be effective upon adjournment of this meeting, and
10 the remainder of this report be filed. Recommendations are listed in order of the topics covered in
11 the body of the report with all modified current policies reconciled in numerical order in Appendix
12 G for clarity.

13
14 *Campaign Memorabilia*

15
16 **Recommendation 1:** Campaign memorabilia may not be distributed in the Not for Official
17 Business (NFOB) bag. (New HOD Policy)

18
19 **Recommendation 2:** Policy G-610.020, Rules for AMA Elections, paragraph 10 be amended by
20 addition and deletion to read as follows:

- 21
22 (10) Campaign expenditures and activities should be limited to reasonable levels necessary for
23 adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the~~
24 ~~Annual Meeting in the non-official business bag and at one campaign party. Campaign~~
25 ~~gifts should only be distributed during the Annual Meeting and not mailed to delegates and~~
26 ~~alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall~~
27 ~~establish a limit on allowable expenditures for campaign-related gifts. In addition to these~~
28 ~~giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or~~
29 ~~sticker. No other e~~Campaign memorabilia and giveaways that include a candidate's name
30 or likeness may not shall be distributed at any time; (Modify Current HOD Policy)

31
32 *Stickers, Buttons, and Pins*

33
34 **Recommendation 3:** Campaign stickers, pins, buttons and similar campaign materials are
35 disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies,
36 state and regional delegations and health related causes that do not include any candidate identifier.
37 These pins should be small, not worn on the badge and distributed only to members of the
38 designated group. General distribution of any pin, button or sticker is disallowed. (New HOD
39 Policy)

40
41 **Recommendation 4:** Policy G-610.020, Rules for AMA Elections, paragraph 8 be amended by
42 deletion to read as follows:

- 43
44 (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party.
45 However, a candidate may be featured at only one party, which includes: (a) being present
46 in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside
47 of the party venue, ~~or (c) distributing stickers, buttons, etc. with the candidate's name on~~
48 ~~them.~~ At these events, alcohol may be served only on a cash or no-host bar basis; (Modify
49 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)

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

- 3
4 (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall
5 administration of our AMA elections, although balloting is conducted under the
6 supervision of the chief teller and the Committee on Rules and Credentials. The Speaker
7 and Vice Speaker will advise candidates on allowable activities and when appropriate will
8 ensure that clarification of these rules is provided to all known candidates. The Speaker, in
9 consultation with the Vice Speaker and the Election Committee, is responsible for
10 declaring a violation of the rules; (Modify Current HOD Policy)
11

12 *Review of Implementation*
13

14 **Recommendation 41:** After an interval of 2 years a review of our election process, including the
15 adopted recommendations from this report, be conducted by the Speaker and, at the Speaker's
16 discretion the appointment of another election task force, with a report back to the House. (New
17 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:

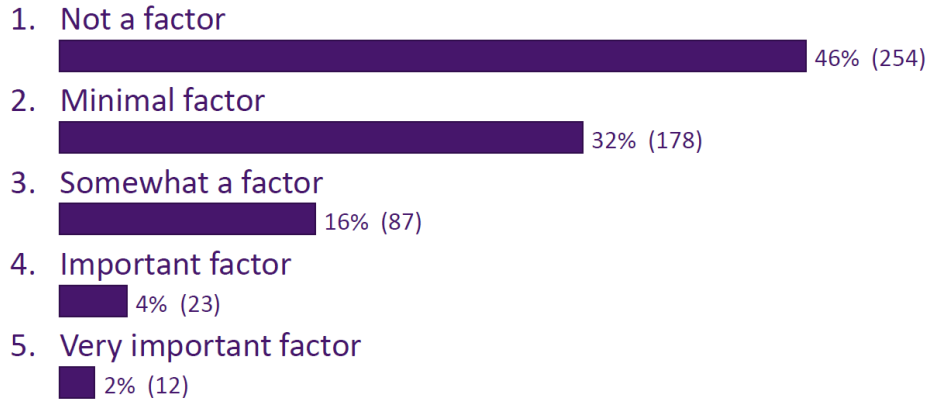
- a. Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
- b. Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
- c. Separating the logistical 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

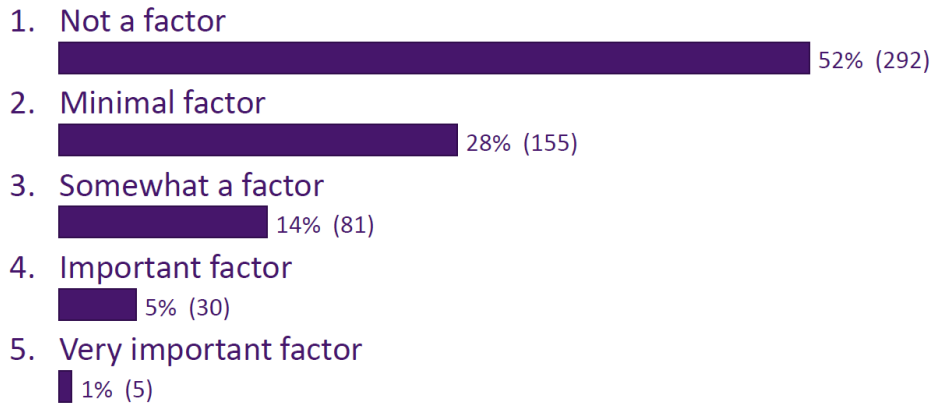
RESOLVED, That the task force report back to the HOD at the 2019 Interim Meeting.

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

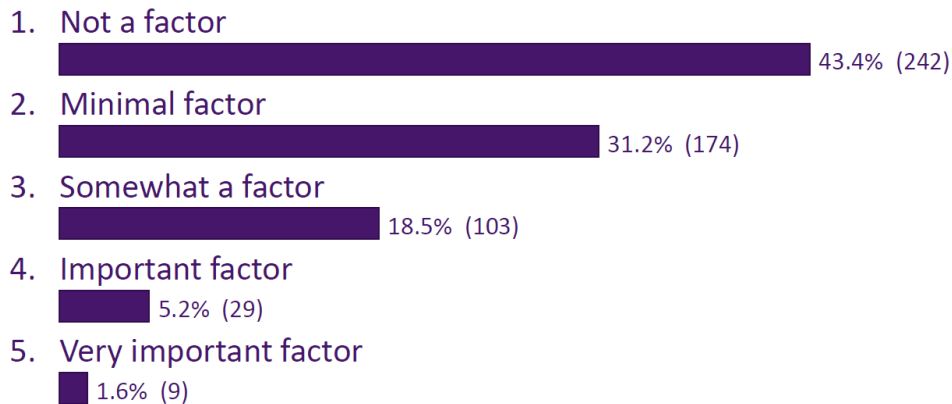
In determining your vote, how much of a factor are campaign brochures in the “Not For Official Business” bag?



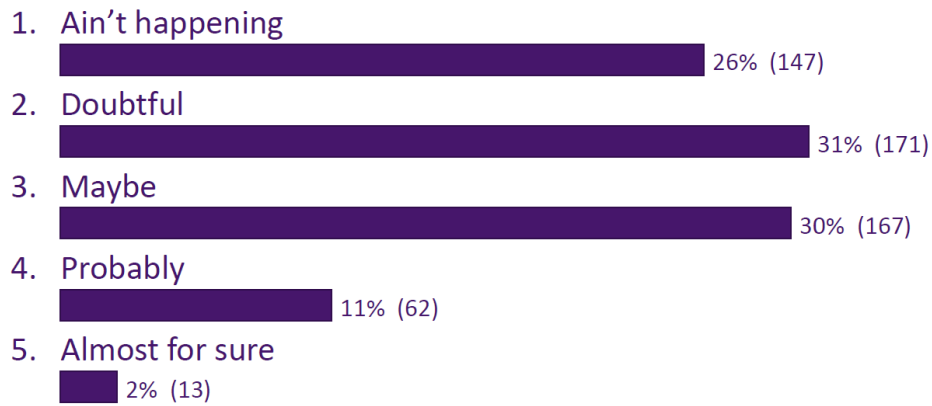
In determining your vote, how much of a factor are campaign brochures mailed to you before the meeting?



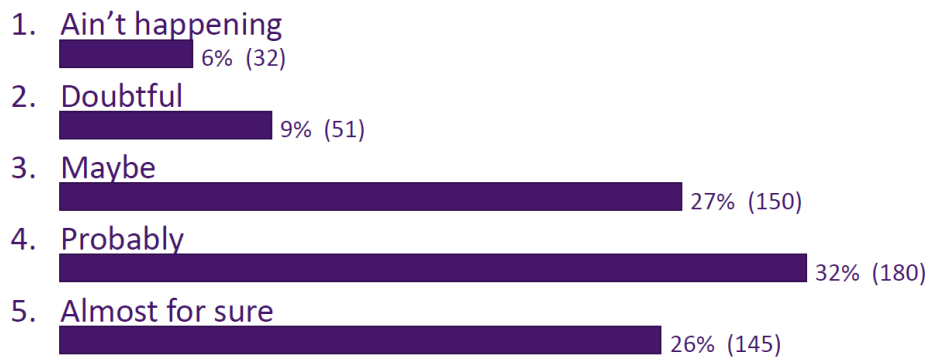
In determining your vote, how much of a factor are campaign materials emailed to you before the meeting?



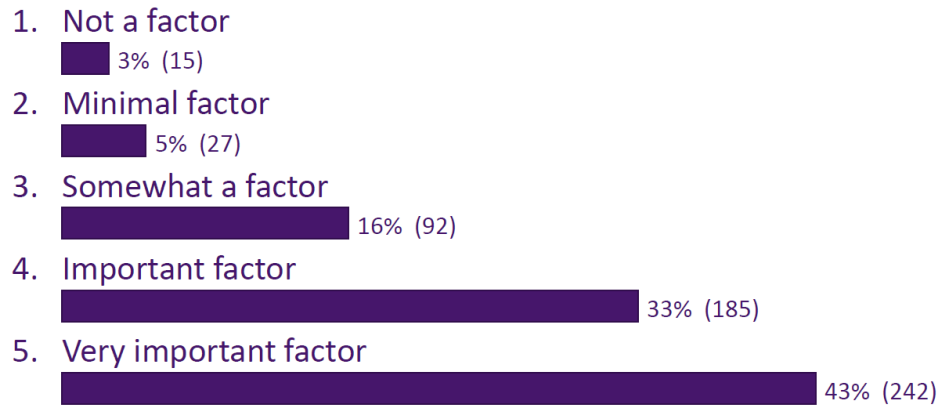
How likely are you to look at candidates' websites?



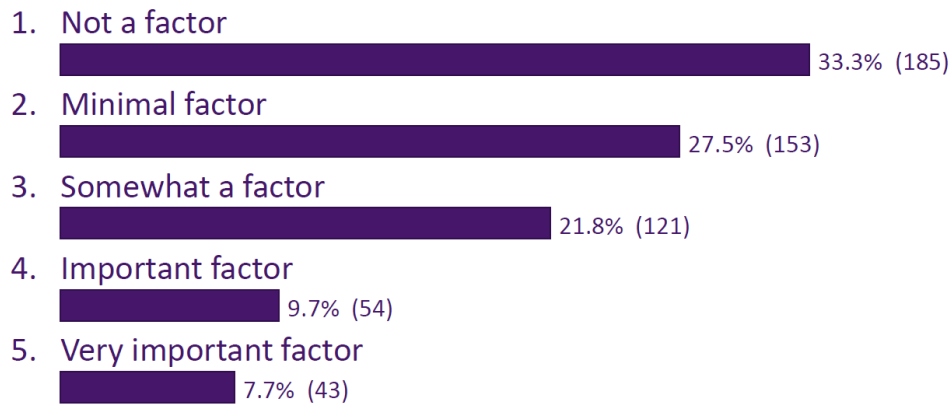
How likely are you to look at an enhanced AMA Elections website that would include links to the candidates' website and answers to specific questions given to candidates in advance?



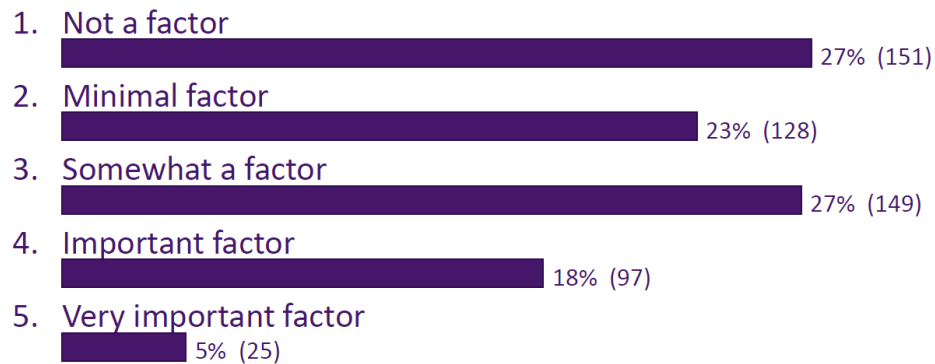
In determining your vote, how much of a factor is the interview process?



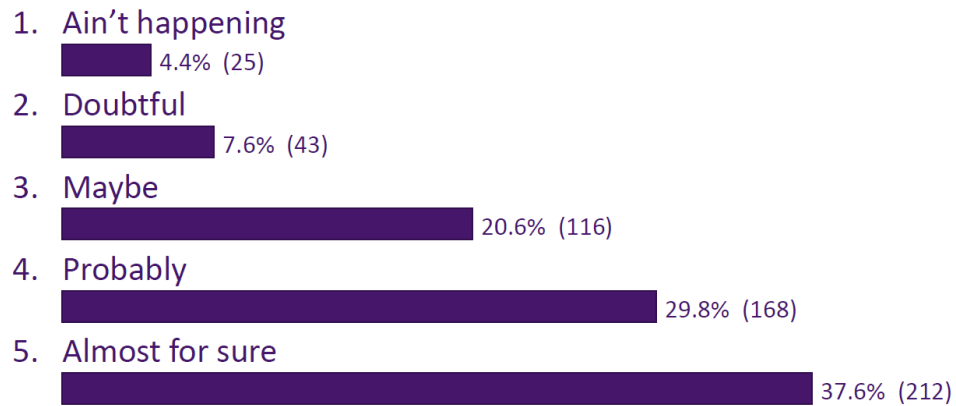
In determining your vote, how much of a factor are campaign receptions?



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



Would you attend a combined candidates party?



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)
 43% (228)
2. Hold the seat/s open until the next Interim meeting and elect at that meeting
 26% (139)
3. Hold the seat/s open until the next Annual meeting elections
 12% (63)
4. Require candidates to vacate their current position at the time of elections, regardless of the outcome
 19% (99)

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
 4% (23)
2. I get input from my caucus or delegation, but make my own decision
 61% (342)
3. I feel somewhat pressured to vote for particular candidates selected by my caucus or delegation
 15% (82)
4. I am strongly pressured by my delegation or caucus to vote for certain candidates
 15% (85)
5. My vote is mandated by my caucus or delegation
 5% (29)

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 not 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 e~~Campaign 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

1 Whereas, The ongoing overdose crisis has spared no demographic, professional, or geographic
2 stratum, and although efforts to bring substance use disorder and its treatment out of the
3 shadows have made substantial inroads, outdated thinking, policies, and practices persist; and
4

5 Whereas, Opioid-agonist therapy is the standard treatment for opioid use disorder (OUD) and
6 maintenance with methadone or buprenorphine sharply reduces the risks of relapse, overdose,
7 and death, making it possible for patients to regain control of their personal and occupational
8 functions; and
9

10 Whereas, Despite the well-documented effectiveness of such MAT (medication assisted
11 treatment), however, MAT for opioid use disorder remains vastly underutilized in the United
12 States and elsewhere; and
13

14 Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine
15 concluded that “there is no scientific evidence that justifies withholding medications from OUD
16 patients in any setting” and stated that such practices amount to “denying appropriate medical
17 treatment”; and
18

19 Whereas, The American Society of Addiction Medicine recommends that “Healthcare
20 professionals should be offered the full range of evidence-based treatment, including medication
21 for addiction, in whatever setting they receive treatment; and
22

23 Whereas, Physicians have a 15-20% lifetime risk of psychiatric or substance use disorder; and
24

25 Whereas, Despite the evidence for effectiveness, doctors themselves are often prevented
26 access to opioid agonist therapy due to policies and/or practices of physicians health and
27 wellness programs, state medical boards, hospital and health system credentialing bodies, and
28 employers which prevent such access; therefore be it
29

30 RESOLVED, That our American Medical Association affirm that no physician or medical student
31 should be presumed to be impaired by substance or illness solely because they are diagnosed
32 with a substance use disorder (New HOD Policy); and be it further
33

34 RESOLVED, That our AMA affirm that no physician or medical student should be presumed
35 impaired because they and their treating physician have chosen medication for opioid use
36 disorder (MOUD) to address the substance use disorder, including methadone and
37 buprenorphine (New HOD Policy); and be it further

1 RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness
2 programs, state medical boards, hospital and health system credentialing bodies, and
3 employers to help end stigma and discrimination against physicians and medical students with
4 substance use disorders and allow and encourage the usage of medication for opioid use
5 disorder (MOUD), including methadone or buprenorphine, when clinically appropriate and as
6 determined by the physician or medical student (as patient) and their treating physician, without
7 penalty (such as restriction of privileges, licensure, ability to prescribe medications or other
8 treatments, or other limits on their ability to practice medicine), solely because the physician's or
9 medical student's treatment plan includes MOUD (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA survey physician health programs and state medical boards and
12 report back about whether they allow participants/licensees to use MOUD without punishment,
13 or exclusion from practicing medicine or having to face other adverse consequences. (Directive
14 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

1 Whereas, The severe acute respiratory syndrome coronavirus 2 (COVID-19) has spread
2 globally, causing nearly 3 million deaths worldwide since first appearing in 2019; and
3

4 Whereas, We express our condolences to all individuals affected by COVID-19 and their
5 families and friends; and
6

7 Whereas, We are grateful for the monumental efforts and sacrifices made by health care
8 professionals, public health workers, research scientists, pharmaceutical companies,
9 government workers, elected officials and others for their continuing contributions in battling this
10 pandemic; and
11

12 Whereas, The phenomenal speed with which effective vaccines against this virus was made
13 possible by basic research grants from the National Institutes of Health and other public
14 institutions, further developed and rapidly manufactured in large quantities by investor-owned
15 pharmaceutical companies; and
16

17 Whereas, Death and other serious complications of COVID infection are more common in
18 individuals with underlying heart disease, diabetes, hypertension and other chronic illnesses;
19 and
20

21 Whereas, The COVID pandemic has unmasked pre-existing severe socioeconomic and racial
22 disparities in the delivery of health care in the United States; and
23

24 Whereas, The public health crisis related to the COVID pandemic is even more deadly in many
25 less economically developed countries around the world; and
26

27 Whereas, COVID vaccine is soon to be available to all Americans desiring to be vaccinated; and
28

29 Whereas, COVID variants continue to appear both in the US and abroad, threatening repeated
30 surges of COVID infections, particularly in those who do not have access to vaccination; and
31

32 Whereas, Resurgence of COVID-19 anywhere in the world potentially affects the United States;
33 and
34

35 Whereas, There is a moral and ethical imperative to provide effective medical care to all
36 patients regardless of their economic status or citizenship; therefore be it

1 RESOLVED, That our American Medical Association call for the cooperation of all governments
 2 and international agencies to share data, research and resources for the production and
 3 distribution of medicines, vaccines and personal protective equipment (Directive to Take
 4 Action); and be it further

5
 6 RESOLVED, That our AMA promote and support efforts to supply COVID vaccines to health
 7 care agencies in other parts of the world to be administered to individuals who can't afford them.
 8 (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

Reference Committee A

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?

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

1 Whereas, According to the AMA Council on Medical Service (CMS), employers and insurance
2 companies are increasingly implementing programs (i.e., Financial Incentive Programs or FIPs)
3 that offer patients financial incentives when they use shopping tools to compare prices on health
4 care items and services and choose lower-cost options; and

5
6 Whereas, According to the CMS, empowering patients to pursue health care can minimize
7 financial burden and reduce societal health care costs; and

8
9 Whereas, According to the CMS, while considering these potential benefits of FIPs, it is critical
10 to ensure that patients are empowered to make fully informed decisions about their health care,
11 that they are never coerced into accepting lower-cost care if it could jeopardize their health, and
12 that programs that influence patient decision-making should be transparent about quality and
13 cost; and

14
15 Whereas, Multiple studies have shown that, on average, Medicaid recipients use emergency
16 rooms (ERs) more often than those with private insurance for non-urgent conditions; and

17
18 Whereas, Some states have implicated a copay system in an attempt to deter the overutilization
19 of ERs, but there is concern that such costs have been shown to cause people, especially those
20 within low-income and vulnerable populations, to forgo necessary care; and

21
22 Whereas, One multistate [study](#) found that charging higher copayments did not reduce ER use
23 by Medicaid recipients and reasons postulated for this finding include that copays are hard to
24 enforce, since ERs are legally obligated to examine anyone who walks through the doors,
25 whether or not they can pay; and

26
27 Whereas, One concept that has been implemented in a few states provides Medicaid recipients
28 with a prepaid card to cover a certain number of copays for ER visits and that any unutilized
29 amount on that copay card could be converted to a financial reward at the end of the year; and

30
31 Whereas, Some states have set up a 24-hour hotline staffed by nurses who can advise people
32 about whether they are having a true medical emergency; and

33
34 Whereas, There is also a compelling need to be very cautious regarding the creation of
35 disincentives for patients who are in need of care; therefore be it

- 1 RESOLVED, That our American Medical Association study and report on the positive and
 2 negative experiences of programs in various states that provide Medicaid beneficiaries with
 3 incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or
 4 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

1 Whereas, There are many patients with Medicaid or no health insurance that physicians care for
2 routinely for little or no payment; and
3

4 Whereas, It may be politically complicated to rectify this fact directly with improved payments to
5 physicians; and
6

7 Whereas, One way to offset the problem would be to use tax deduction techniques; and
8

9 Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or
10 Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes
11 providing tax deductions or credits for the provision of care to the medically uninsured and
12 underinsured; therefore be it
13

14 RESOLVED, That our American Medical Association advocate for legislation that would allow
15 physicians who take care of Medicaid or uninsured patients to receive some financial benefit
16 through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use
17 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

1 Whereas, The coverage and utilization of telehealth expanded rapidly during the COVID-19
2 pandemic; and¹

3
4 Whereas, Many commercial health insurance companies have voluntarily expanded telehealth
5 coverage during the pandemic, albeit in some cases on a more restrictive or less generous
6 basis than the Medicare program; and

7
8 Whereas, Our AMA has drafted model legislation that requires health insurance companies to
9 offer telehealth coverage and to reimburse for those services “on the same basis and to the
10 same extent” that the insurer would have if the same service were rendered in-person; and²

11
12 Whereas, There are ongoing discussions across the nation regarding whether to require health
13 insurance companies to offer telehealth coverage and whether to require health insurance
14 companies to provide payment parity for telehealth services; and³

15
16 Whereas, Physicians have recognized that telehealth can improve clinical outcomes, patient
17 experience, costs, and professional satisfaction; and⁴

18
19 Whereas, Insurance companies in Florida and elsewhere have argued that enacting legislation
20 that would require them to offer telehealth coverage and to adhere to payment parity
21 requirements will definitively, significantly increase insurance premiums; and

22
23 Whereas, Physician advocates urgently need additional data concerning the effects of
24 telehealth coverage requirements and payment parity requirements on health insurance
25 premiums to respond to the cost-related concerns being propagated by insurers; and

26
27 Whereas, Physician advocates may struggle to successfully enact telehealth coverage and
28 payment parity legislation in the absence of research that can be used to respond to the
29 assertion that such legislation will definitively and significantly increase health insurance
30 premiums; and

31
32 Whereas, Our AMA is equipped to perform or commission research concerning the effects of
33 telehealth coverage and payment parity requirements, including the effect that such policies
34 may have on health insurance premiums; therefore be it

- 1 RESOLVED, That our American Medical Association conduct or commission a study on the
2 effect that telemedicine services have had on health insurance premiums, focusing on the
3 differences between states that had telehealth payment parity provisions in effect prior to the
4 pandemic versus those that did not, and report back at the 2021 Interim Meeting of the AMA
5 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.

References:

1. FAIR Health Monthly Telehealth Regional Tracker, <https://www.fairhealth.org/article/fair-health-tracker-shows-continuing-growth-in-telehealth>
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

1 Whereas, A coronary artery calcium score (CACS) measured by computed tomography is a
2 noninvasive, low-radiation diagnostic test that correlates with cardiovascular outcomes¹; and
3

4 Whereas, Screening with CACS can help guide the course of clinical management in the
5 borderline-and intermediate-risk patients with 10-year cardiovascular risk of 5% to 20%,
6 particularly those with risk-enhancing factors, e.g., chronic kidney disease, metabolic syndrome,
7 an elevated high sensitivity C-reactive protein, a positive ankle-brachial index, or a positive
8 family history^{2,3} by the American College of Cardiology and American Heart Association 2019
9 Primary Prevention Guidelines; and
10

11 Whereas, CACS is not covered by insurance except in the state of Texas⁴, and the out-of-
12 pocket costs range from \$49-\$1209, which may represent a barrier for patients who may not be
13 able to afford the test, but are likely to derive benefit from the results of the test; and
14

15 Whereas, A low-cost and no-charge CACS strategy has been tested in Cleveland, Ohio⁵,
16 demonstrating a striking increase in CACS utilization in lower income patients, the black
17 population and women; therefore be it
18

19 RESOLVED, That our American Medical Association seek national and/or state legislation
20 and/or a national coverage determination (NCD) to include coronary artery calcium scoring
21 (CACS) for patients who meet the screening criteria set forth by the American College of
22 Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar
23 covered preventive service, consistent with the current policy in the state of Texas (Directive to
24 Take Action); and be it further
25

26 RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that
27 hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who
28 are unable to afford this test, as a means to enhance disease detection, disease modification
29 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.

References

1. Detrano R, Guerci AD, Carr JJ, et al. Coronary calcium as a predictor of coronary events in four racial or ethnic groups. *N Engl J Med* 2008;358:1336-1345.
2. Roberts ET, Horne A, Martin SS, et al. Cost-effectiveness of coronary artery calcium testing for coronary heart and cardiovascular disease risk prediction to guide statin allocation: the Multi-Ethnic Study of Atherosclerosis (MESA). *PLoS One* 2015;10(3):e0116377.
3. Arnett DK, Blumenthal RS, Albert MA et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation* 2019;140(11) e596–e646.
4. Naghavi M, Maron DJ, Kloner RA, et al. Coronary artery calcium testing: A call for universal coverage *Prev Med Rep*. 2019;15:100879. Published 2019 May 2. doi:10.1016/j.pmedr.2019.100879.
5. Al-Kindi SG, Costa M, Tashtish N et al., No Charge Coronary Calcium Risk Assessment. *J Am Coll Cardiol* 2020;76(10):1259-1262.

Reference Committee B

BOT Report(s)

- 07 Council on Legislation Sunset Review of 2011 House Policies
- 14 Pharmaceutical Advertising in Electronic Health Record Systems

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

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

1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA's policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5

- 6 1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall
7 exist. A policy will typically sunset after ten years unless action is taken by the House to retain
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall
9 reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.
10
- 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the House identifying policies that
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall
20 provide a succinct, but cogent justification (f) The Speakers shall determine the best way for
21 the House to handle the sunset reports.
22
- 23 3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy
24 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more
25 current policy, or has been accomplished.
26
- 27 4. The AMA councils and the House should conform to the following guidelines for sunset: (a)
28 when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House
31 of Delegates Reference Manual: Procedures, Policies and Practices.
32
- 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
- 35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Board of Trustees recommends that the House of Delegates policies that are listed in the
 4 appendix to this report be acted upon in the manner indicated and the remainder of this report be
 5 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~~ <u>Quality Improvement</u> Organization Sanctions	Our AMA supports vigorously pursuing with appropriate ~~peer review~~ <u>quality improvement</u> 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~~ <u>Quality Improvement</u>	The AMA supports (1) careful review of the involvement of the Office of Inspector General in ~~peer review~~ <u>quality improvement</u> 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;~~ (43) 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; (54) 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; (65) 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 (76) 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

1 INTRODUCTION

2
3 At the 2019 Interim Meeting Policy D-478.961, “Pharmaceutical Advertising in Electronic Health
4 Record Systems,” was adopted by the House of Delegates (HOD). The policy directs our American
5 Medical Association (AMA) to study the prevalence and ethics of direct-to-physician advertising at
6 the point of care, including advertising in electronic health record (EHR) systems.

7
8 This report provides information about the prevalence and ethical implications of direct-to-
9 physician pharmaceutical advertising, with specific attention to advertisements and alerts in the
10 EHR.

11 BACKGROUND

12
13
14 Pharmaceutical companies have a long history of marketing to physicians in the clinical setting. In
15 recent years access to physicians has become more challenging for pharmaceutical companies—
16 nearly half of physicians restrict visits from pharmaceutical sales representatives.¹ Perhaps making
17 up for the decline in direct access, the amount of money spent on marketing and advertising to
18 physicians continues to increase. Pharmaceutical companies spent \$20.3 billion on marketing to
19 physicians in 2016 through advertisements, samples, direct payments, personal visits and gifts from
20 pharmaceutical representatives, up from \$15.6 billion 20 years earlier.² Spending on advertising in
21 digital channels such as search engines and social media platforms also continues to increase.³ The
22 EHR system has risen as a unique opportunity to directly provide information about prescription
23 drugs to prescribers, given that physicians spend more than 15 minutes per patient in the EHR.⁴
24 However, there are ethical concerns with pharmaceutical advertising in the EHR, and whether this
25 is a common practice or a sustainable business model for EHRs has yet to be explored.

26 AMA POLICY

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28
29 The AMA supports the American pharmaceutical manufacturing industry in its efforts to develop
30 and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit
31 of the American people (Policy H-100.995, “Support of American Drug Industry”). In addition, the
32 AMA supports a ban on direct-to-consumer advertising for prescription drugs and implantable
33 medical devices (H-105.988, “Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and
34 Implantable Devices”).

35
36 *AMA Code of Medical Ethics* Opinion 9.6.7, “Direct-to-Consumer Advertisements of Prescription
37 Drugs,” states physicians should remain objective about advertised tests, drugs, treatments, and
38 devices, avoiding bias for or against advertised products. The Opinion also states physicians should

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 FDA¹², 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 analysis²⁴—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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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

1 Whereas, Across the U.S., states passed telemedicine legislation in 2020 (pre-pandemic) that
2 allows providers to use telehealth, including asynchronous technology, to establish the
3 physician-patient relationship; and
4

5 Whereas, The ability to access health care via telemedicine prior to the pandemic was available,
6 but not widely used; and
7

8 Whereas, Payments to physicians for telemedicine vary by carrier and were significantly less
9 than in-person visits prior to COVID-19; and
10

11 Whereas, The onset and severity of COVID-19 caused a rapid implementation of telemedicine
12 by physicians of many specialties, and patients rapidly embraced the technology as often the
13 only means to access non-emergent medical care; and
14

15 Whereas, Through directives of the federal and state governments, payors waived co-pays and
16 deductibles and increased payment for telemedicine and telephonic services equal to in-person
17 visits during COVID-19 which reduced barriers for patients to access medical care; and
18

19 Whereas, The federal government and states took action to allow physicians and other health
20 care clinicians to use non-HIPAA compliant platforms if necessary to enhance patients' use of
21 technology to access health care; therefore be it
22

23 RESOLVED, That our American Medical Association address the importance of at least a
24 365-day waiting period after the COVID-19 public health crisis is over before commencement of
25 audits aimed at discovering the use of non-HIPAA compliant modes and platforms of
26 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

1 Whereas, Homemade, difficult to trace firearms are increasingly turning up at crime scenes; and

2
3 Whereas, The most important part of a gun is the lower receiver - the 'chassis' of the weapon,
4 the part housing vital components such as the hammer and trigger; and

5
6 Whereas, Under federal law, the lower receiver is considered a firearm - while other gun
7 components do not require a background check for purchase; and

8
9 Whereas, Dozens of companies sell what are known as "80%" lower receivers - ones that are
10 80% finished, lack a serial number and can be used to make a homemade gun; and

11
12 Whereas, The Gun Control Act (1968) and the Brady Gun Violence Prevention Act (1993) allow
13 for homemade weapons; and

14
15 Whereas, Ghost guns don't have any unique markings and therefore present black holes to
16 police investigators; and

17
18 Whereas, Ghost guns provide an easy avenue for people banned from owning guns to obtain
19 them; and

20
21 Whereas, According to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of
22 all weapons recovered by the bureau in California were homemade; and

23
24 Whereas, These weapons have been connected with mass shootings, police shootouts and
25 arms trafficking; therefore be it

26
27 RESOLVED, That our American Medical Association support state and federal legislation and
28 regulation that would subject homemade weapons to the same regulations and licensing
29 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

1 Whereas, The gay/trans panic (to be more inclusive will use “LGBTQ+ panic”) defense strategy
2 is a legal strategy that uses a victim’s sexual orientation or gender identity/expression as an
3 excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent and
4 lethal behavior (1); and

5
6 Whereas, The LGBTQ+ panic defense strategy gives defendants three options of defense: 1)
7 insanity or diminished capacity, 2) provocation, 3) self-defense (3); and

8
9 Whereas, To claim:

10
11 - insanity, defendants claim that the sexual orientation or gender of the victim is enough to
12 induce insanity (1);

13
14 - provocation, defendants claim “victim’s proposition, sometimes termed a “non-violent sexual
15 advance” was sufficiently “provocative” to induce the defendant to kill the victim”(1);

16
17 - self-defense, “defendants claim they believed that the victim, because of their sexual
18 orientation or gender identity/expression, was about to cause the defendant serious bodily
19 harm (3)”; and

20
21 Whereas, Studies have shown that jurors with higher homonegativity and religious
22 fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more
23 lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and

24
25 Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA
26 recognized that no such condition exists; and

27
28 Whereas, Many murder sentences have been reduced or defendants have been acquitted using
29 the LGBTQ+ panic defense strategy such as in the Matthew Shepard case, to successfully
30 mitigate a charge from murder to criminally negligent manslaughter as recently as 2018 (1); and

31
32 Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation
33 is the motivator of 17% of hate crime attacks with one in four transgender people becoming the
34 victim of a hate crime in their lifetime (4, 5); and

35
36 Whereas, the LGBTQ+ panic defense has only been banned in 11 states as of February 2021,
37 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

1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and
4

5 Whereas, These advantages have not resulted in cost savings (or even stability) for
6 consumers--in fact cost increases born by consumers have been outsized and correlated with
7 consolidation; and
8

9 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
10 efficiency; and
11

12 Whereas, These "efficiencies" rarely, if ever, benefit the consumer; and
13

14 Whereas, These combined entities (especially vertical ones) are more competitive among their
15 competitors than the uncombined ones (accelerating further consolidation); and
16

17 Whereas, The combined entities are also positioned (due to their superior access to capital) to
18 unfairly disrupt entities at other points in the supply chain such as medical practices, community
19 pharmacies, and safety net hospitals; therefore be it
20

21 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
22 health payers (except non-profit HMO's) from owning or operating other entities in the health
23 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)

Reference Committee C

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

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

1 Whereas, There is a physician shortage facing our nation; andⁱ

2
3 Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or
4 older and in retirement age this year; andⁱ

5
6 Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now
7 more than ever the need for a sufficient and robust physician workforce; andⁱ

8
9 Whereas, An unprecedented number of physicians now plan to retire in the next year and many
10 of whom are under 45 years old and therefore would be retiring earlier than expected by
11 workforce shortage predictors due to COVID-19; andⁱⁱ

12
13 Whereas, 8% of physicians surveyed across the United States have closed their practices
14 during the pandemic, amounting to approximately 16,000 closed practices further exacerbating
15 the shortage of healthcare providers; andⁱⁱⁱ

16
17 Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across
18 specialties who have reported loss of staff, lack of reimbursement, and closure of independent
19 physician practices during the COVID-19 pandemic; and^{iii,iv}

20
21 Whereas, Young physicians are expected to be part of the workforce for many years to come,
22 yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were
23 under 60 years old with primary care physicians (PCPs) accounting for a disproportionate
24 number of these HCW deaths; and^{v,vi}

25
26 Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already
27 predicted to be between 2,500 and 17,000 by 2030; and^{vii}

28
29 Whereas, During the pandemic, the shortage has been amplified in that New York City has had
30 the highest COVID-19 death rate in the country with NYS accounting for the greatest number of
31 HCW deaths in the USA; and^{v,viii}

32
33 Whereas, 73% of medical students graduated with debt in 2020; and^{ix}

34
35 Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting
36 for inflation, affecting newer generations of students and physicians substantially more than past
37 ones; and^x

1 Whereas, The average medical student debt is \$207,003--an approximately 28% increase in the
2 past 10 years--however, the average physician ultimately pays \$365,000-\$440,000 for an
3 educational loan with interest; and^{ix,x,xi}

4
5 Whereas, In the United States, 50% of low-income medical school graduates have educational
6 debt that exceeds \$100,000; and^x

7
8 Whereas, The financial barrier to entry into medical school is significant in that over half of
9 medical students belong to the top quintile of US household income, with 20-30% of students
10 belonging to the top 5% of income; however, only less than 5% of students come from the
11 lowest quintile of US household income; and^x

12
13 Whereas, A recent study found that higher debt levels among medical students is more likely to
14 motivate them to choose higher paying specialties than primary care specialties; and^{xii}

15
16 Whereas, Higher burdens of educational debt has been demonstrated to cause residents to
17 place greater emphasis on financial considerations when choosing a specialty; and^{xiii}

18
19 Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that
20 has been studied previously in natural disasters and has been shown to persist for years;
21 and^{xiv,xv}

22
23 Whereas, It is well-established that health inequities existed before the pandemic in that
24 individuals with low socioeconomic status are more likely to also be from minority populations,
25 and are more likely to have worse health outcomes; and^{xvi}

26
27 Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest
28 burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and^{xvii}

29
30 Whereas, Over 27 million Americans have lost their employer-sponsored health insurance
31 during the pandemic; thus, we will need more physicians now than ever before to address these
32 disparities and rising needs in health care; and^{xviii}

33
34 Whereas, 72% of physicians surveyed across specialties reported loss of income during the
35 pandemic, with over half of these respondents reporting losses of 26% or more; andⁱⁱⁱ

36
37 Whereas, Policies modeled to include provisions for debt relief or increase in incomes were
38 found by one study to be more likely to incentivize students to choose primary care physician
39 specialties; and^{xix}

40
41 Whereas, Current AMA policies support methods to alleviate debt burden but do not address
42 debt cancellation specifically; and

43
44 Whereas, \$50 billion of the initial CARES Act Provider Relief Fund were allocated to support the
45 current healthcare system by giving hospitals and providers funding "to support health care-
46 related expenses or lost revenue attributable to COVID-19..."; however, funding formulas based
47 on market shares of Medicare costs and total patient revenue are most likely to bankrupt
48 independent physicians, specifically primary care providers; and^{xx,xxi}

49
50 Whereas, One study found that primary care internists whose medical education were funded
51 through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

1 significantly less net present value than primary care internists who received military or private
2 funding; and^{xxii}

3
4 Whereas, Medical education debt has been shown to be a significant barrier for
5 underrepresented minorities and low/middle income strata students to choose medicine for a
6 career; and^{xxii}

7
8 Whereas, A key strategy to address health needs of underserved communities involves
9 recruiting students from these communities as they may be more likely to return to address local
10 health needs; and^{xxiii}

11
12 Whereas, One medical school has created a debt-free program for matriculated students and
13 saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in
14 applicants from groups underrepresented in medicine to help address socioeconomic and
15 racial/ethnic disparities in the medical workforce and in healthcare; and^{xxiv}

16
17 Whereas, There is currently a student debt forgiveness resolution in the United States Senate to
18 cancel \$50,000 of student debt which will also apply to all medical students, training physicians,
19 and early career physicians; and^{xxv}

20
21 Whereas, Data suggests women and people of color will benefit most from such debt
22 cancellation because they are most in need; therefore be it^{xxv}

23
24 RESOLVED, That our American Medical Association study the issue of medical education debt
25 cancellation and consider the opportunities for integration of this into a broader solution
26 addressing debt for all medical students, physicians in training, and early career physicians.
27 (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 policies 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

1 Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of
2 patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use
3 the title "physician"; and
4

5 Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health
6 care advertising materials to clarify designate the level of education, skills, and training of all
7 health care professionals promising their services"; and
8

9 Whereas, The Centers for Medicare and Medicaid Services defines a resident as "an intern,
10 resident, or fellow who is formally accepted, enrolled, and participating in an approved medical
11 residency program including programs in osteopathy, dentistry, and podiatry as required to
12 become certified by the appropriate specialty board"; and
13

14 Whereas, There has been an increase in the number of physician assistant (PA) and nurse
15 practitioner (NP) postgraduate programs, many of which are inappropriately referred to as
16 "residencies" or "fellowships"; and
17

18 Whereas, On September 3rd, 2020, every major academic emergency medicine association
19 issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship'
20 in a medical setting must be limited to postgraduate clinical training of medical school physician
21 graduates within graduate medical education (GME) training programs"; and
22

23 Whereas, Several of these training programs pay their first-year trainees more than the
24 first-year residents in physician residencies; therefore be it
25

26 RESOLVED, That our American Medical Association recognize that the terms "medical
27 student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in
28 the healthcare setting, all connote completing structured, rigorous, medical education
29 undertaken by physicians; thus these terms should be reserved to describe physician roles
30 (New HOD Policy); and be it further
31

32 RESOLVED, That our AMA work with relevant stakeholders to define appropriate labels for
33 postgraduate clinical and diagnostic training programs for non-physicians that recognizes the
34 rigor of these programs but prevents role confusion associated with the terms "resident,"
35 "residency," "fellow," or "fellowship" (Directive to Take Action); and be it further

1 RESOLVED, That our AMA object to the American Board of Medical Specialists, the American
 2 Osteopathic Association Bureau of Osteopathic Specialists, and their member boards having
 3 designated seats for Nurse Practitioners, Physician Assistants, Certified Registered Nurse
 4 Anesthetists, Anesthesia Assistants, or any other healthcare professional that are independent
 5 from the public member seats (Directive to Take Action); and be it further
 6

7 RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the
 8 expansion of postgraduate clinical training for non-physicians does not divert funding from
 9 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 of 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)

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

Resolution(s)

- 401 Universal Access for Essential Public Health Services
- 402 Modernization and Standardization of Public Health Surveillance Systems

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

1 At the November 2020 Special Meeting of the House of Delegates Resolution 409, introduced by
2 the Medical Student Section, was referred for study. This resolution asked that our American
3 Medical Association (AMA):
4

- 5 (1) advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-
6 control in the United States (Directive to Take Action); and
- 7 (2) encourage relevant stakeholders including but not limited to manufacturers and
8 government agencies to develop, test, and use crowd-control techniques which pose no risk
9 of physical harm. (Directive to Take Action)

10 11 BACKGROUND

12
13 In 2020, protests and demonstrations increased in the United States following the outrage and grief
14 over the killing of George Floyd, Breonna Taylor and other victims of law enforcement-related
15 violence and racism across the country. While an analysis of more than 7,750 demonstrations
16 across the country from May 26, 2020 through August 22, 2020 found that more than 93 percent of
17 Black Lives Matter protests have been peaceful, a small number of protests involved demonstrators
18 engaging in violence.¹ Crowd control tactics used by law enforcement at some anti-racism protests
19 have been called a public health threat, with excessive use of force raising health and human rights
20 concerns as well as undermining freedom of peaceful assembly.^{2,3} Concerns have specifically been
21 raised regarding law enforcement's use of crowd-control weapons (CCWs) or less-lethal weapons
22 (LLWs) against protesters resulting in preventable injury, disability, and death.³
23

24 The right of people to peaceably assemble is protected by the First Amendment to the Constitution.
25 However, this right is not without limitation, as jurisdictions have a duty to maintain public order
26 and safety and may regulate the time, place, and manner of protests. The use of force by law
27 enforcement officers may be necessary and is permitted in certain circumstances. However, law
28 enforcement officers should use only the amount of force necessary to mitigate an incident, make
29 an arrest, or protect themselves or others from harm.⁴
30

31 The American Medical Association has previously studied the issue of law enforcement-related
32 violence. This report will be narrowly focused on the issue of the use of chemical irritants and
33 kinetic impact projectiles for crowd-control in the United States.

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.

1 Tasers, or Conducted Electrical Devices (CEDs) are another LLW often used by law enforcement.
 2 The AMA has existing policy on CEDs, which recommends that law enforcement departments and
 3 agencies should have in place specific guidelines, rigorous training, and an accountability system
 4 for their use that is modeled after available national guidelines. CEDs are outside of the scope of
 5 this report.

6 DISCUSSION

7
 8
 9 Population-level data on protest-related injuries from LLW, including chemical irritants and KIPs,
 10 are not readily available. There are limited regulations on the development of KIPs and
 11 manufacturers are not required to keep records on injuries from their products. Generally, there is
 12 no requirement for law enforcement to collect data on injuries from LLWs and if the data is
 13 collected, it may not be publicly available. Limited studies have attempted to identify these injuries
 14 through emergency department encounters captured through the injury surveillance systems as well
 15 as through injuries reported through traditional and social media. While research has shown that
 16 people of color face a higher likelihood of being killed by police than do White men and women⁷,
 17 morbidity and mortality specific to LLWs and their use in crowd control by race and ethnicity is
 18 unclear. Though it has been observed that crowds comprised largely of people of color have faced a
 19 more aggressive, more militarized approach.⁸

20
 21 Law enforcement agencies oppose some restrictions on LLWs, saying the weapons are a critical
 22 tool to control uncooperative people that stops short of deadly force. Limiting access to LLWs
 23 could increase morbidity and mortality, requiring law enforcement officials to choose a more
 24 deadly form of force. There is some data available to suggest that the use of LLW decreases the
 25 likelihood of suspect injury.^{9,10} For example, the use of pepper spray decreased the likelihood of
 26 suspect injury by 65 percent.¹¹ However, most of this research is focused on CEDs and pepper
 27 spray and is not specific to KIPs or crowd control.

28 *Injury, Disability, and Death from Kinetic Impact Projectiles (KIPs)*

29
 30
 31 A systematic review of the literature on deaths, injuries, and permanent disability from KIPs from
 32 January 1990 to June 2017 identified injury data on 1,984 people.³ Over the 27-year period, 53
 33 people (3 percent) died because of their injuries. Penetrative injuries caused 56 percent of the
 34 deaths, while blunt injuries caused 23 percent, head and neck trauma accounted for nearly 50
 35 percent of deaths, and chest and abdominal trauma accounted for 27 percent.³ Three hundred
 36 people (15 percent of survivors) suffered permanent disability. Many injuries were secondary to
 37 vision loss and abdominal injuries resulting in splenectomies or colostomies. Amputation of a limb
 38 occurred in two individuals.³ Of the 2,135 injuries in the 1,931 people who survived, 71 percent
 39 were severe, with injuries to the skin and extremities being the most frequent.³ Almost all (91.5
 40 percent n=732) head and neck, ocular, nervous, cardiovascular, pulmonary and thoracic, abdominal
 41 and urogenital injuries were severe.³

42
 43 Anatomical site of impact, firing distance, and timely access to medical care were correlated with
 44 injury severity and risk of disability. Morbidity and mortality from KIPs often occurs as a result of
 45 shots to vital organs at close range including the head, neck, chest and abdomen.³ Although the
 46 data are limited, rubber-coated metal bullets and those with composites of metal and plastic appear
 47 to be more lethal than plastic or rubber alone.³ Though there is some evidence that “newer
 48 ‘attenuated energy projectiles’ (with a hollow plastic tip that collapses on impact or a soft sponged
 49 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 be 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, it 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 inflicted 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 equipment³². 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 parent(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

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

1 INTRODUCTION

2
3 Resolution 309-I-19, "Follow-up on Abnormal Medical Test Findings," which was introduced by
4 the Georgia Delegation and referred by the House of Delegates, asked that:

5
6 Our American Medical Association advocate for the adoption of evidence-based
7 guidelines on the process for communication and follow-up of abnormal medical test
8 findings to promote better patient outcomes; and

9
10 Our AMA work with appropriate state and specialty medical societies to enhance
11 opportunities for continuing education regarding professional guidelines and other
12 clinical resources to enhance the process for communication and follow-up of
13 abnormal medical test findings to promote better patient outcomes.

14 15 CURRENT AMA POLICY

16
17 Existing AMA policy addresses medical test results and follow-up (see Appendix for full text).
18 AMA Policy D-260.995, "Improvements to Reporting of Clinical Laboratory Results," encourages
19 the usability and standardization of clinical laboratory reports including clearly identifiable
20 diagnoses and test results. AMA Policy H-155.994, "Sharing of Diagnostic Findings," encourages
21 providers to develop mechanisms for the sharing of diagnostic findings to avoid duplication of
22 expensive diagnostic tests and procedures. AMA Policies H-478.979, "Quality Payment Program
23 and the Immediate Availability of Results in Certified Electronic Health Record Technologies,"
24 and D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health
25 Records," address best practices for patient portals including education and sharing of medical test
26 results. AMA Policy H-425.968, "Non-Physician Screening Tests," advocates for requiring
27 consultation with a patient's primary care physician or usual source of care if a screening test
28 shows a positive or otherwise abnormal test result.

29 30 BACKGROUND

31
32 Medical testing is essential for providing quality health care. Testing services are frequently
33 divided between the branches of laboratory medicine, anatomic pathology, and medical imaging.
34 Other medical specialties also perform many additional forms of testing including mental health
35 assessments, hearing and vision tests, sleep apnea tests, and neurocognitive tests. Test results are
36 used for diagnostic and other medical decision-making purposes, with interpretation taking into
37 account additional patient context.¹

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 “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 resources²⁵ 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

1 systems to facilitate patient communication. This opinion outlines the design and implementation
2 of a tracking and reminder system to help handle notification of test results.²⁸

3
4 The Office of the National Coordinator for Health Information Technology (ONC) offers Safety
5 Assurance Factors for EHR Resilience (SAFER) Self-Assessment Guides to address safety
6 concerns faced by health care organizations.²⁹ The SAFER guide on Test Results Reporting and
7 Follow-Up includes a checklist and recommended practice worksheets with rationale and examples
8 for how to implement. The self-assessment facilitates engagement of clinician leadership to reach
9 consensus on priorities, resources and methods of ensuring that recommended practices for
10 communication and management of diagnostic test result are in place.

11
12 The ECRI Institute's Partnership for Health IT Patient Safety offers a toolkit called "Closing the
13 Loop: Using Health IT to Mitigate Delayed, Missed, and Incorrect Diagnoses Related to Diagnostic
14 Testing and Medication Changes."³⁰ Their recommendations include "to develop and apply IT
15 solutions to communicate the right information (including data needed for interpretation), to the
16 right people, at the right time, in the right format, using the right channel." This recommendation
17 focuses on three domains: improving communication, tracking of loop closure, and linking
18 acknowledgment to action taken.

19
20 The Agency for Healthcare Research and Quality (AHRQ) has released a "Toolkit for Rapid-Cycle
21 Patient Safety and Quality Improvement."³¹ This toolkit uses the "Plan-Do-Study-Act (PDSA)
22 Method for Practice Improvement" to survey the entire staff to highlight potential quality and
23 safety issues that can be addressed to improve the reliability of the office testing process. The
24 toolkit includes a patient engagement survey and handout to assess patient experiences. This
25 approach can help offices to determine how often patients with abnormal results are not being
26 monitored through follow-up and what the consequences may be. The tool also facilitates auditing
27 medical records to examine whether patients were notified of results within the timeframe specified
28 by the office policy and to plan for improvements and measure progress.

29 30 *Potential Impacts for Physicians and Patients*

31
32 Notification preferences can evolve over time and include tradeoffs in terms of ease of use and
33 degree of security.^{32,33} The ideal communication method may include an office visit, phone call,
34 text, postal mail, email and/or the use of an online patient portal. Preferences may vary between
35 patients and between different types of test results. Guidelines around notification should be
36 flexible so that they can be tailored to meet various practice and patient needs.

37
38 Overall, flexibility in approach to reporting abnormal and critical results is likely to continue to
39 remain desirable. Flexibility is also needed to support communication policies that are standard
40 practice in medicine such as brief embargo periods to enable care coordination, closing the referral
41 loop, consultation, discussion of complex findings, care team planning, and/or other medically
42 appropriate purposes. Such flexibility may be more readily accomplished by tailored clinical
43 practice guidelines and local programs rather than broad mandates via additional regulation. For
44 example, MQSA has been associated with decreasing variability in mammography since enacted in
45 1992, but in general such regulatory approaches may be considered complex and inflexible and
46 may increase administrative burden. MQSA also does not cover newer screening technologies.¹

47
48 Online patient portals have the capacity to provide early access to test results in the absence of
49 meaningful interpretation by a physician.³⁴ While patients should have timely access to their test
50 results, providing such information without additional context or explanation at the appropriate

1 health literacy level may increase anxiety for some patients.³⁵ Patients may also encounter
2 challenges accessing the results or require additional support.³⁶

3
4 Finally, systems reporting test results should be designed in a manner that minimizes unnecessary
5 notification burden and avoids information overload and alert fatigue for physicians.³⁷ Guidelines
6 offered by medical specialty societies have the potential to help optimize appropriate notification
7 frequency and response. Additional research is needed to develop best practices for communication
8 of test results including via patient portals and apps.

9 10 CONCLUSION

11
12 This resolution asks the AMA to advocate for the adoption of evidence-based guidelines and
13 enhance the availability of continuing education on the process for communication and follow-up
14 of abnormal medical test findings to promote better patient outcomes. While the AMA has
15 extensive policy on medical test reporting and certainly agrees that reporting test results in a timely
16 manner is an important patient safety issue, it is the role of national medical specialty societies to
17 develop evidence-based guidelines on communicating with patients regarding abnormal test results.
18 Communication requirements may vary by facility or jurisdiction and communication preferences
19 may vary between patients and between different types of test results. As outlined in this report,
20 there are a number of existing tools and resources that physicians can leverage to facilitate
21 communication with patients on abnormal and critical test findings.

22 23 RECOMMENDATIONS

24
25 The Board of Trustees recommends that the language below be adopted in lieu of Resolution 309-I-
26 19 and the remainder of this report be filed.

27
28 Our American Medical Association encourages relevant national medical specialty societies to
29 develop and disseminate evidence-based guidelines for communication and follow-up of
30 abnormal and critical test results to promote better patient outcomes. (New HOD Policy)

31
32 Our AMA will work with appropriate state and medical specialty societies to highlight relevant
33 education regarding the communication and follow-up of abnormal and critical medical test
34 findings to promote better patient outcomes. (Directive to Take Action)

35
36 Our AMA supports the development of best practices and other clinical resources for
37 communication of test results, including via patient portals and applications, and encourages
38 additional research to ensure these innovative approaches and tools reach their potential to help
39 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.

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

1 Whereas, We have not gained a consensus on what are the essential public health services that
2 everyone in our country is entitled to receive; and
3

4 Whereas, Various independent public health entities have developed their own proprietary list of
5 “essential” and/or “foundational” public health services; and
6

7 Whereas, Public health governance structures and funding sources vary greatly by region,
8 state, and jurisdiction across the country; and
9

10 Whereas, Compartmentalized, competitive, unpredictable, and inflexible funding leaves many
11 health departments without financing for all essential public health services and necessary
12 capabilities; and
13

14 Whereas, A lack of coordination and information sharing between local jurisdictions, state
15 departments of health, and federal entities reduces the effectiveness of interventions to manage
16 nationwide public health problems, including outbreaks; and
17

18 Whereas, We have no means to accurately capture capabilities and spending on essential
19 public health services in every jurisdiction in order to determine if there is a current lack of
20 universal access; and
21

22 Whereas, We have no means of collecting outcomes data in order to monitor the access to and
23 cost effectiveness of our public health interventions; therefore be it
24

25 RESOLVED, That our American Medical Association study the options and/or make
26 recommendations regarding the establishment of:
27

- 28 1. a list of all essential public health services that should be provided in every
29 jurisdiction of the United States;
- 30 2. a nationwide system of information sharing and intervention coordination in
31 order to effectively manage nationwide public health issues;
- 32 3. a federal data system that can capture the amount of federal, state, and local
33 public health capabilities and spending that occurs in every jurisdiction to
34 assure that their populations have universal access to all essential public
35 health services; and
- 36 4. a federal data system that can capture actionable evidence-based outcomes
37 data from public health activities in every jurisdiction (Directive to Take Action);
38 and be it further

- 1 RESOLVED, That our AMA prepare and publicize annual reports on current efforts
- 2 and progress to achieve universal access to all essential public health services.
- 3 (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

1 Whereas, Epidemiologic data collection is paramount to targeting and implementing evidence-
2 based control measures to protect the public's health and safety; and
3

4 Whereas, Accurate data collection is essential for anticipation of, preparation for, and response
5 to a public health crisis; and
6

7 Whereas, Combining data from various sources, identifying the most relevant data for
8 meaningful results, and standardizing collection and reporting to enable actionable analysis are
9 chronic challenges--not the lack of data; and
10

11 Whereas, Technologies and surveillance systems play an integral, increasing, and evolving role
12 in supporting public health responses to outbreaks or other urgent public health events; and
13

14 Whereas, Responding to urgent public health issues expeditiously requires balancing the speed
15 of response with the need for accurate data and information to support the implementation of
16 control measures; and
17

18 Whereas, The analyses and results are only as good as the quality of the data collected; and
19

20 Whereas, The COVID-19 pandemic demonstrated significant discrepancies in how data was
21 collected, reported, analyzed, and ultimately acted upon at local, state and federal levels of
22 government; and
23

24 Whereas, Standardization of data collection and data fields including local, state and federal
25 should help with such discrepancies; therefore be it
26

27 RESOLVED, That our American Medical Association advocate for the modernization and
28 standardization of public health surveillance systems data collection by the Centers for Disease
29 Control and Prevention and state and local health departments, including but not limited to
30 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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Reference Committee E

Resolution(s)

- 501 Ensuring Correct Drug Dispensing
- 502 Scientific Studies Which Support Legislative Agendas
- 503 Access to Evidence-Based Addiction Treatment in Correctional Facilities

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(JUN-21)

Introduced by: New York

Subject: Ensuring Correct Drug Dispensing

Referred to: Reference Committee E

1 Whereas, Medication errors affect millions of people every year with the clinical and economic
2 consequences of those errors having been widely documented; and
3

4 Whereas, Much is known about hospital medication errors because of their well-established
5 reporting systems for continuous monitoring; and
6

7 Whereas, In a hospital a dispensing error can be detected and prevented by nursing personnel
8 at the administration stage; and
9

10 Whereas, *The New York Times* published an article entitled "*How Chaos at Chain Pharmacies*
11 *Is Putting Patients at Risk*" which stated that pharmacists at companies such as CVS, Rite Aid
12 and Walgreens described understaffed and chaotic workplaces which made it difficult to perform
13 their jobs safely and can lead to "dispensing errors"; and
14

15 Whereas, Currently, in some states, any drug dispensed must bear a label on its container
16 which identifies the name and address of the owner of the establishment in which it was
17 dispensed, the date compounded, the number of the prescription under which it is recorded in
18 the pharmacist's prescription files, the name of the prescriber, the name and address of the
19 patient, and the directions for the use of the drug by the patient as given upon the prescription;
20 and
21

22 Whereas, When a prescription is filled in a retail pharmacy, the last checkpoint for safety is the
23 patient or caregiver who may not have the training and knowledge to know that the dispensed
24 drug is actually the medication prescribed; therefore be it
25

26 RESOLVED, That our American Medical Association request that the United States Food and
27 Drug Administration work with the pharmaceutical and pharmacy industries to facilitate the
28 ability of pharmacies to ensure that a color photo of a prescribed medication and its dosage is
29 attached to the sales receipt to ensure that the drug dispensed is that which has been
30 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

1 Whereas, An important tool in advancing an organization's agenda is the ability to produce
2 scientific or economic studies as evidence for supporting such a position; and
3

4 Whereas, An important tool in advancing an organization's agenda is collaborating with diverse
5 groups who together can present a unified perspective on a particular issue; and
6

7 Whereas, The AMA regularly works with numerous and varied organizations to build allies and
8 obtain research data in support of its efforts to achieve its key public health and legislative
9 goals; and
10

11 Whereas, The goals of organized medicine and allied organizations include advocacy on behalf
12 of patients and public health in addition to physicians; and
13

14 Whereas, Advocacy supported by scientific and economic information carries more weight and
15 benefits those advocacy efforts; and
16

17 Whereas, Opponents of the policy goals of organized medicine often have the capacity to
18 produce such studies; and
19

20 Whereas, The recent debate before Congress to address surprise medical bills often found
21 physician organizations at odds with the perspectives of not only the insurance industry, but
22 also the business, labor, and patient advocacy organizations as well as numerous think
23 tanks; and
24

25 Whereas, This debate reiterated the importance of developing allies and research data to help
26 work to achieve these public health and legislative goals; therefore be it
27

28 RESOLVED, That our American Medical Association continue and expand its efforts to work
29 with allied groups, health care policy influencers such as think tanks, and entities that can
30 produce high quality scientific evidence, to help generate support for the AMA's key advocacy
31 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

1 Whereas, Provisional data indicate drug overdose deaths exceeded 90,000 during the 12
2 months ending in September 2020,¹ the highest number of overdose deaths ever recorded
3 during a 12-month period; and
4

5 Whereas, Opioid overdose death rates are increasing more rapidly among Black Americans
6 than white Americans;² and
7

8 Whereas, Experts attribute the acceleration in drug overdose deaths to the disruption to daily
9 life due to the COVID-19 pandemic;³ and
10

11 Whereas, Scholars have noted early indicators that the pandemic is increasing racial inequities
12 in overdose deaths;⁴ and
13

14 Whereas, Incarcerated individuals are 129 times more likely to die from overdose within the first
15 two weeks after release when compared to the general U.S. population⁵ and nearly five percent
16 of all deaths from illicit opioids occurs among people who were released from jail or prison in the
17 past month;⁶ and
18

19 Whereas, Black adults are 5.9 times as likely to be incarcerated than whites and Hispanics are
20 3.1 times as likely to be incarcerated as whites;⁷ and
21

22 Whereas, Effective substance use disorder treatment, including medications, is key to
23 preventing relapse, overdose and death;⁸ and
24

25 Whereas, Individuals who are receiving medications for the treatment of opioid use disorder
26 (OUD) prior to incarceration may be forced to discontinue such treatment, and those with
27 untreated OUD are often not offered evidence-based and life-saving treatment upon entering
28 jail⁹ or prison;¹⁰ and
29

30 Whereas, Federal Medicaid funds are prohibited by law from being used for health care in jails
31 and prisons (“the inmate exclusion clause” of the 1965 Social Security Act), and law generally
32 prevents payment for medical care furnished to a Medicare beneficiary who is incarcerated or in
33 custody at the time the services are delivered; and
34

35 Whereas, Our AMA has endorsed the use of medications for OUD in prisons, encouraged public
36 funding for such programs, and supported the establishment of post-incarceration programs to
37 continue OUD; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-430.987, "Opiate
2 Replacement Therapy Programs in Correctional Facilities," by addition and deletion to read as
3 follows:

4
5 **Opiate Replacement Therapy Programs Medications for Opioid Use Disorder in**
6 **Correctional Facilities H-430.987**

7 1. Our AMA endorses: (a) the medical treatment model of employing ~~opiate replacement~~
8 ~~therapy (ORT)~~ medications for opioid use disorder (OUD) as an effective therapy in treating
9 ~~opiate-addicted~~ the standard of care for persons with OUD who are incarcerated; and (b) ~~ORT~~
10 ~~for opiate-addicted~~ medications for persons with OUD who are incarcerated, an endorsement in
11 collaboration with the National Commission on Correctional Health Care and the American
12 Society of Addiction Medicine.

13 2. Our AMA advocates for legislation, standards, policies and funding that ~~encourage~~ require
14 correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use~~
15 ~~disorder~~, including initiation and continuation of ~~opiate replacement therapy~~ medications for
16 OUD, in conjunction with ~~counseling~~ psychosocial treatment when available and desired by the
17 person with OUD, in correctional facilities within the United States and that this apply to all
18 ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are
19 pregnant, postpartum, or parenting.

20 3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~
21 require correctional facilities within the United States to work in ongoing collaboration with
22 addiction treatment physician-led teams, case managers, social workers, and pharmacies in the
23 communities where patients, including ~~pregnant women~~ individuals who are pregnant,
24 postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD
25 ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and
26 medication for preventing overdose deaths, including naloxone (or any other medication that is
27 approved by the United States Food and Drug Administration for the treatment of an opioid
28 overdose), and help ensure post-incarceration medical coverage and accessibility to mental
29 health and substance use disorder treatments, including medications for addiction treatment
30 medication-assisted therapy.

31 4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify
32 opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid
33 withdrawal syndrome for all persons upon entry. (Modify Current HOD Policy); and be it further

1 RESOLVED, That our AMA amend policy H-430.986, "Health Care While Incarcerated," by
2 addition and deletion to read as follows:

3
4 1. Our AMA advocates for adequate payment to health care providers, including primary care
5 and mental health, and addiction treatment professionals, to encourage improved access to
6 comprehensive physical and behavioral health care services to juveniles and adults throughout
7 the incarceration process from intake to re-entry into the community.

8 2. Our AMA supports partnerships and information sharing between correctional systems,
9 community health systems and state insurance programs to provide access to a continuum of
10 health care services for juveniles and adults in the correctional system.

11 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications
12 from juveniles and adults who are incarcerated.

13 4. That our AMA encourage state Medicaid agencies to work with their local departments of
14 corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have
15 been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility
16 determination for Medicaid.

17 5. Our AMA ~~encourages~~ advocates for states to suspend rather than terminate Medicaid
18 eligibility of juveniles and adults upon intake into the criminal justice ~~legal~~ system and
19 throughout the incarceration process, and to reinstate coverage when the individual transitions
20 back into the community.

21 6. Our AMA ~~urges~~ advocates for Congress to repeal the "inmate exclusion" of the 1965 Social
22 Security Act that bars the use of federal Medicaid matching funds from covering healthcare
23 services in jails and prisons, ~~the Centers for Medicare & Medicaid Services (CMS), and state~~
24 ~~Medicaid agencies to provide Medicaid coverage for health care, care coordination activities~~
25 ~~and linkages to care delivered to patients up to 30 days before the anticipated release from~~
26 ~~adult and juvenile correctional facilities in order to help establish coverage effective upon~~
27 ~~release, assist with transition to care in the community, and help reduce recidivism.~~

28 7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS)
29 to revise the Medicare statute and rescind related regulations that prevent payment for medical
30 care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the
31 services are delivered.

32 8.7. Our AMA advocates for necessary programs and staff training to address the distinctive
33 health care needs of incarcerated women and adolescent females who are incarcerated,
34 including gynecological care and obstetrics care for pregnant and postpartum women
35 individuals who are pregnant or postpartum.

36 9.8. Our AMA will collaborate with state medical societies, relevant medical specialty societies,
37 and federal regulators to emphasize the importance of hygiene and health literacy information
38 sessions, as well as information sessions on the science of addiction, evidence-based addiction
39 treatment including medications, and related stigma reduction, for both inmates individuals who
40 are incarcerated and staff in correctional facilities.

41 10.9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in
42 order to accelerate access to comprehensive health care, including mental health and
43 substance abuse disorder services, and improve health outcomes among this vulnerable patient
44 population, as well as adequate funding; and (b) the collaboration of correctional health workers
45 and community health care providers for those transitioning from a correctional institution to the
46 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.

References:

1. Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
2. Furr-Holden D, Milam AJ, Wang L, Sadler R. African Americans now outpace whites in opioid-involved overdose deaths: a comparison of temporal trends from 1999 to 2018. *Addiction*. 2021;116(3):677-683. doi:10.1111/add.15233
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5. Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates [published correction appears in *N Engl J Med*. 2007 Feb 1;356(5):536]. *N Engl J Med*. 2007;356(2):157-165. doi:10.1056/NEJMs064115
6. Mattson CL, O'Donnell J, Kariisa M, Seth P, Scholl L, and Gladden RM. Opportunities to Prevent Overdose Deaths Involving Prescription and Illicit Opioids, 11 States, July 2016– June 2017. *MMWR Morb Mortal Wkly Rep* 2018;67:945-951.
7. The Sentencing Project. Report of The Sentencing Project to the United Nations Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia, and Related Intolerance: Regarding Racial Disparities in the United States Criminal Justice System. March 2018. <https://www.sentencingproject.org/publications/un-report-on-racial-disparities/>
8. National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25310>.
9. Fiscella K, Moore A, Engerman J, Meldrum S. Jail management of arrestees/inmates enrolled in community methadone maintenance programs. *J Urban Health Bull N Y Acad Med*. 2004;81(4):645-654.
10. Nunn A, Zaller N, Dickman S, Trimbur C, Nijhawan A, Rich JD. Methadone and buprenorphine prescribing and referral practices in US prison systems: results from a nationwide survey. *Drug Alcohol Depend*. 2009;105(1-2):83-88.

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

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

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

-
- 1 The Consolidated Financial Statements for the years ended December 31, 2020 and 2019 and the
 - 2 Independent Auditor's report have been included in a separate booklet, titled "2020 Annual
 - 3 Report." This booklet is included in the Handbook mailing to members of the House of Delegates
 - 4 and will be discussed at the Reference Committee F hearing.

2020

AMA ANNUAL REPORT

With the nation in crisis,
you answered with courage.
Thank you, physicians.

#WeStandWithDocs

AMA
AMERICAN MEDICAL
ASSOCIATION

 **Nasdaq**

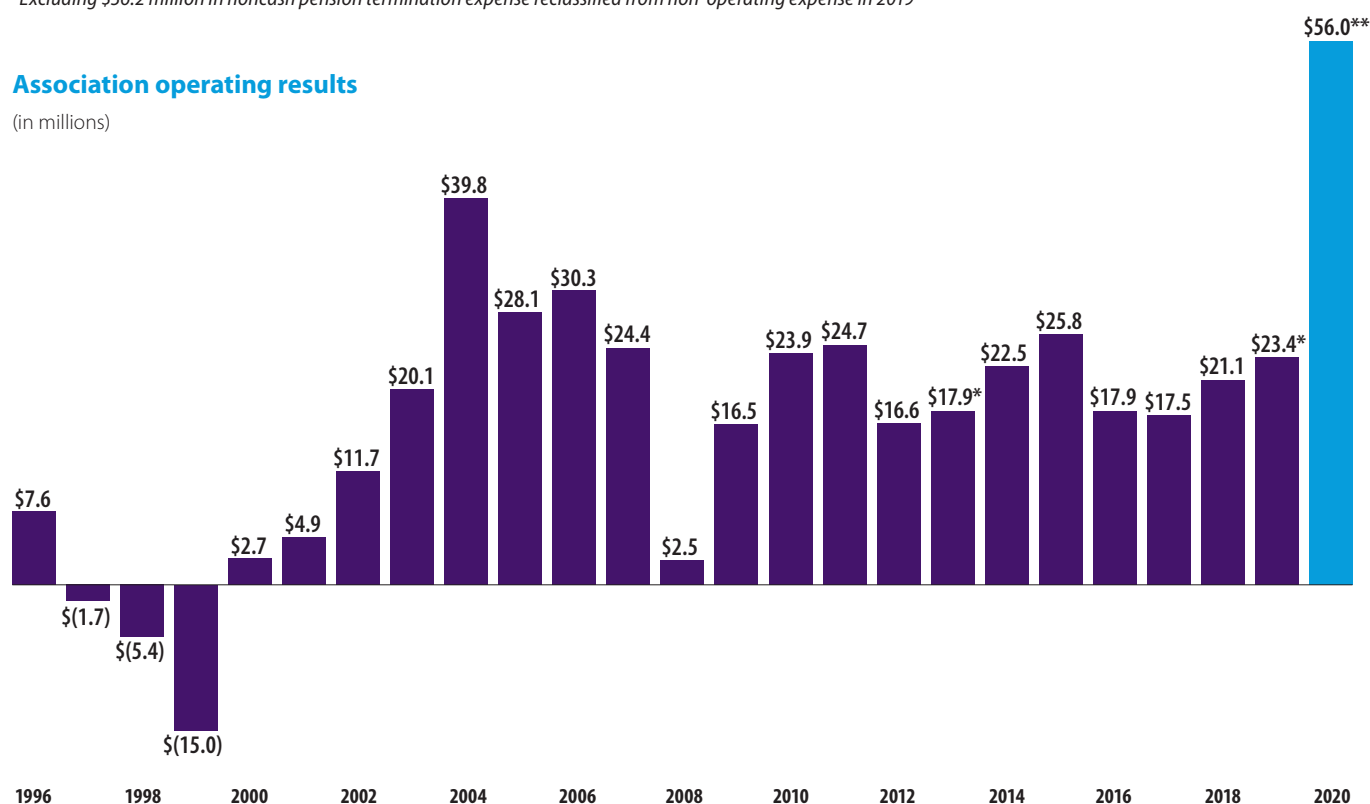
Financial highlights

(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.

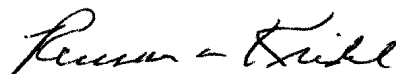
AMA leaders helped drive a national conversation about the importance of science and evidence in guiding our

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.

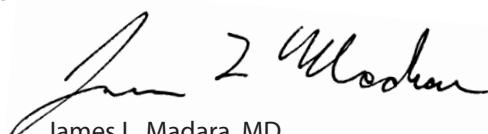
During an incredibly difficult year, the AMA's unprecedented response to COVID-19 brought the meaning of our work into sharp focus, and a recommitment and recalibration of our priorities for the road ahead. To be the physicians' powerful ally in patient care is to always fight on the side of science, equity and improving public health. This is a challenge we proudly accept.



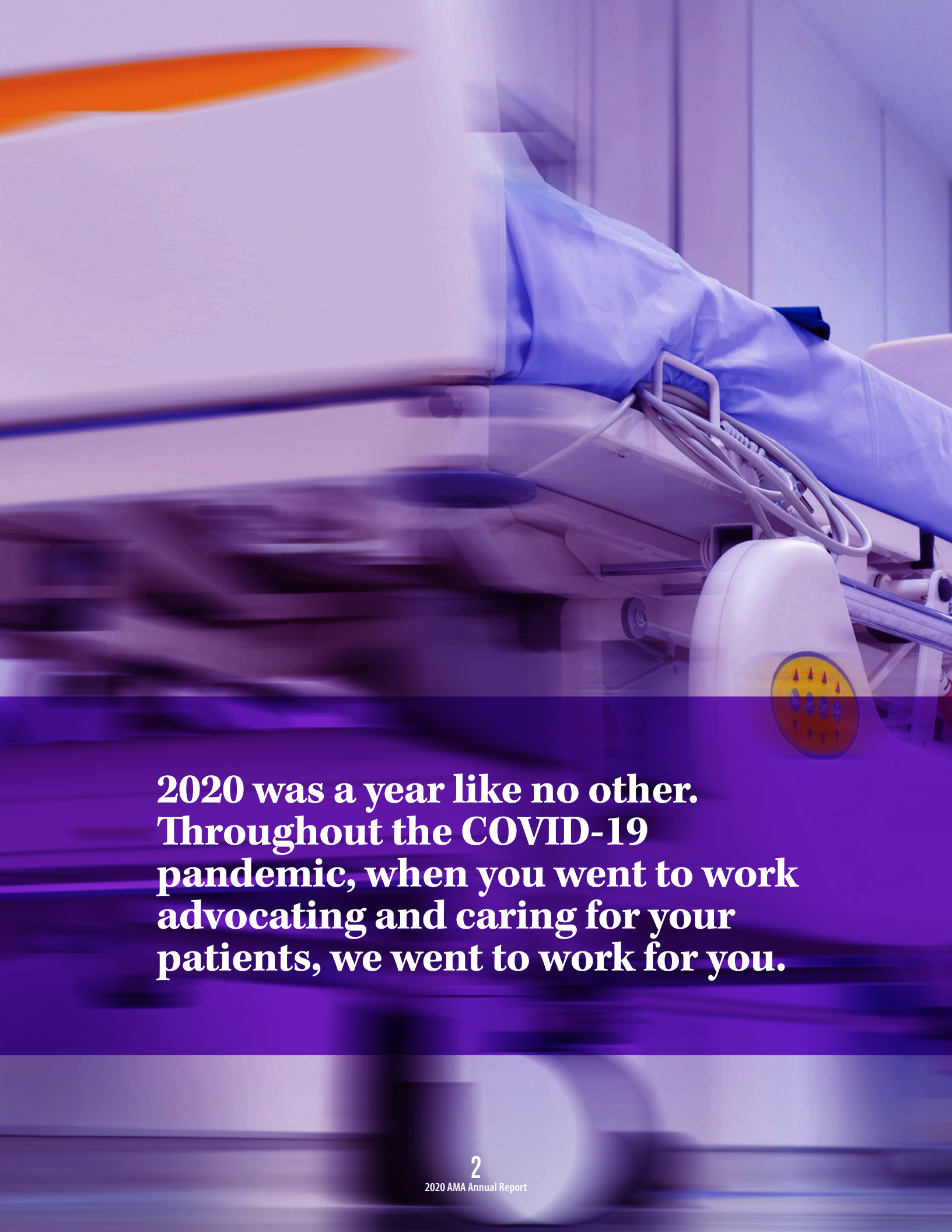
Russ Kridel, MD
Chair, Board of Trustees



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.

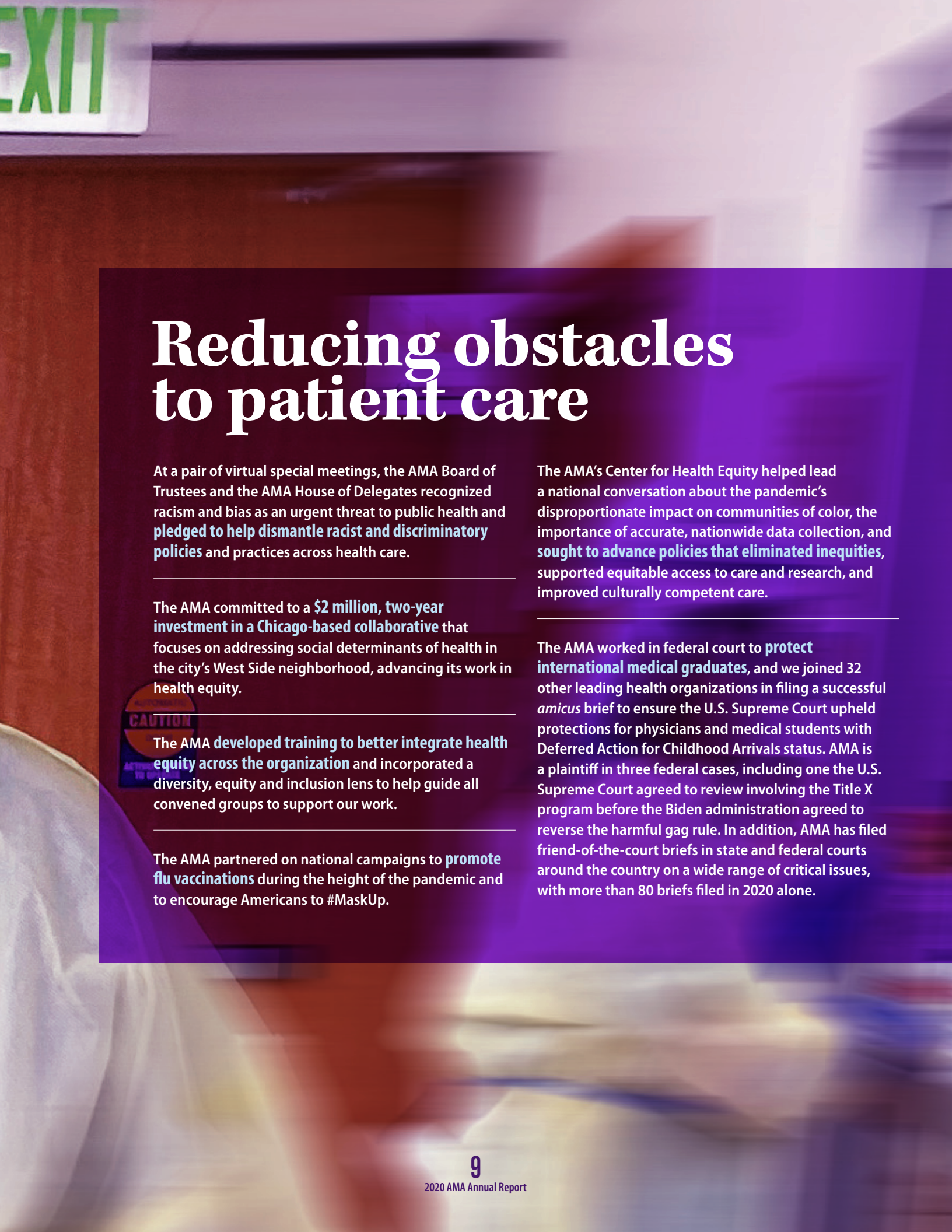
To serve the needs of the medical education community, the AMA developed the comprehensive AMA MedED COVID-19 resource guide as a platform to **inform and engage educators, residents and students in discussions about the pandemic**. AMA's Accelerating Change in Medical Education Consortium and "Reimagining Residency" initiative awarded three GME Innovation Grants at its inaugural (virtual) GME Innovation Summit.



Ankush Bansal, MD
Internal medicine



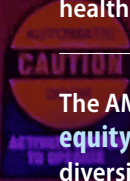
Sunny Jha, MD, MA
Anesthesiology



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.

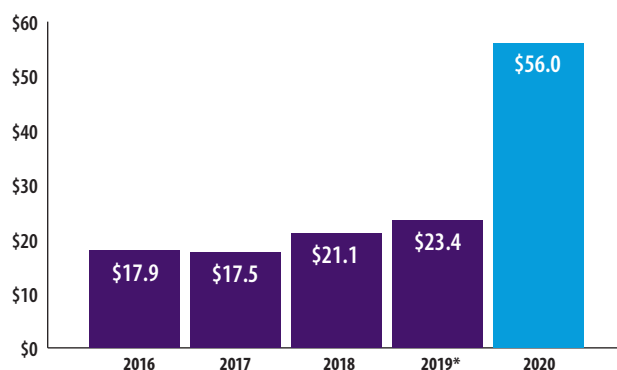
AMA recognized early in 2020 that the impact of COVID-19 was evolving rapidly and its future effects were uncertain. In addition to our responsibility to physicians and the public to be a credible source of information during this pandemic, there was substantial uncertainty about the effects and risks 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.

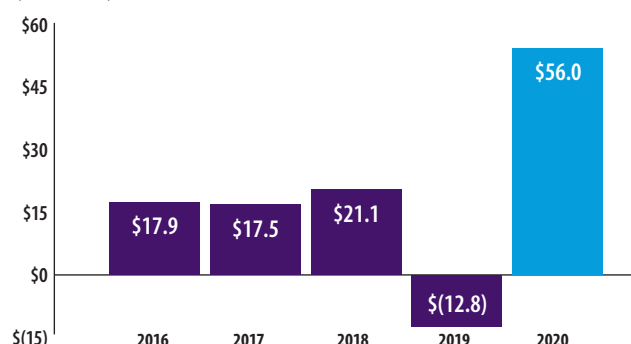
The following pages discuss the 2020 consolidated results from operations, financial position and cash flows, as compared to 2019. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

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.

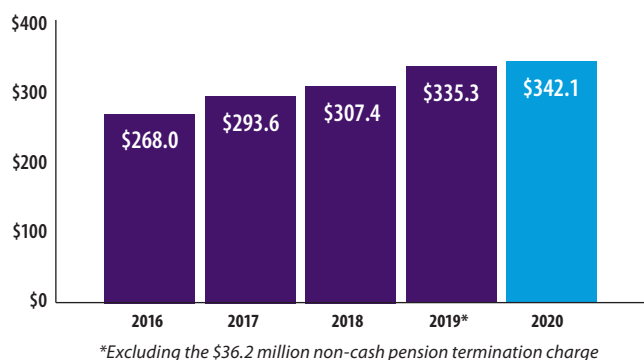
Contribution to general and administrative expenses

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)



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.

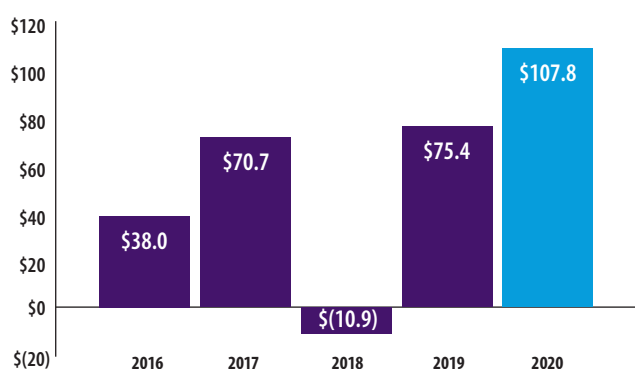
As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include \$2.5 million and \$3.9 million in postretirement plan interest expense and recognized actuarial losses for 2020 and 2019, respectively.

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.

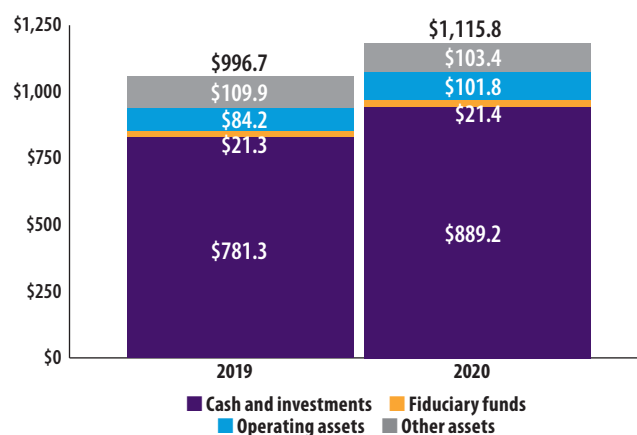
The AMA reported a \$75.4 million increase in association equity in 2019, which included the amount by which revenues exceeded expenses, plus the credits to equity for changes in defined benefit postretirement plans discussed above and less a small decrease in donor-restricted equity.

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.

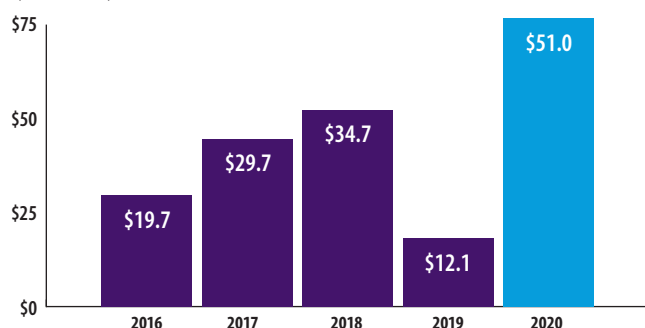
Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

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

(in millions)



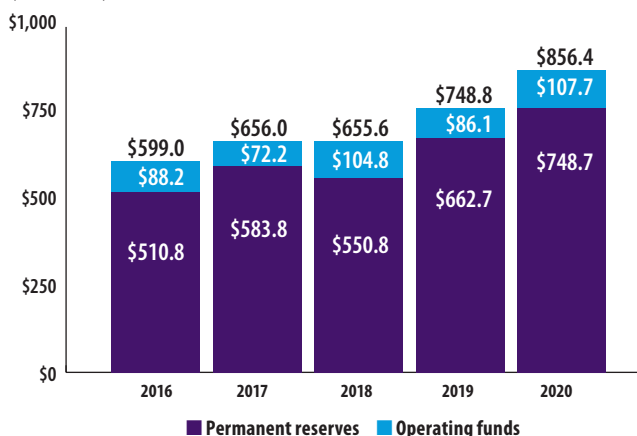
Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash in 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

(in millions)



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

As of year-end 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.

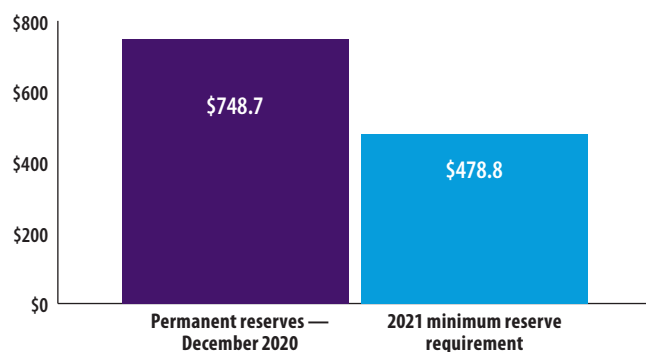
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). 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)



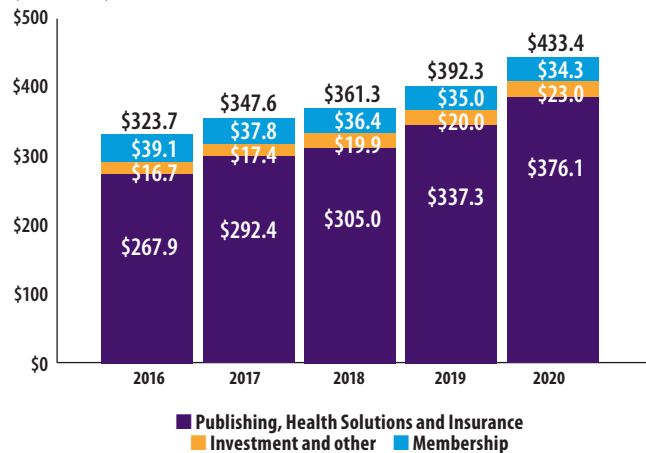
Group operating results

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.

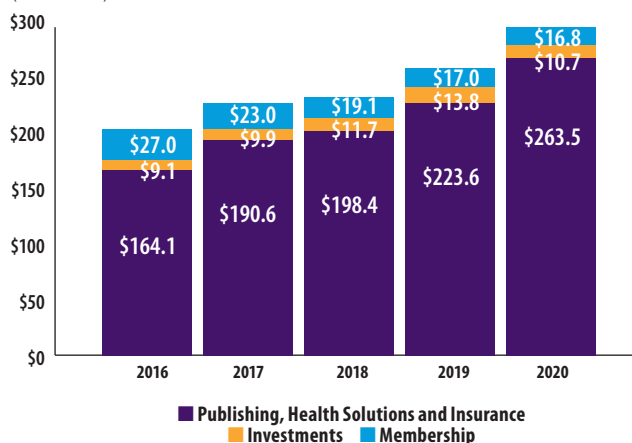
Contribution margin (net expenses)

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.

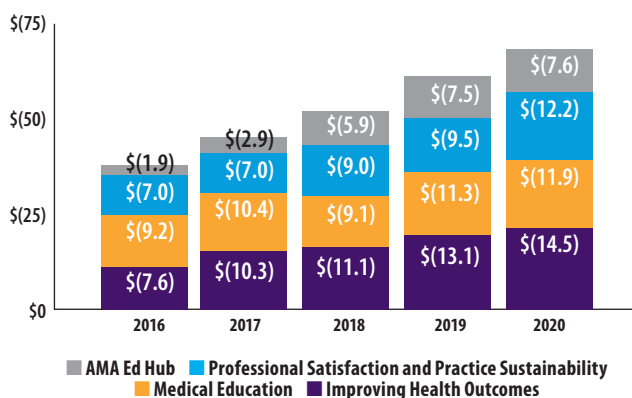
Books and Digital Content contribution margin rose \$34.5 million, largely on the strength of continued growth in royalties and digital product revenues, offset slightly by costs to improve operational and international distribution capability.

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.

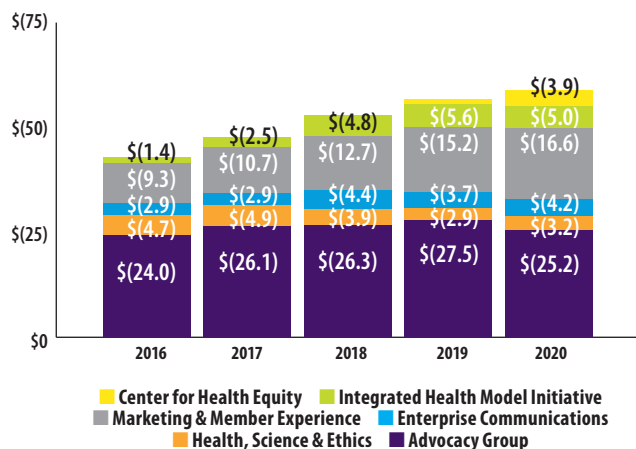
PS2 includes three major streams of work: practice transformation, digital health, and payment and quality, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care.

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

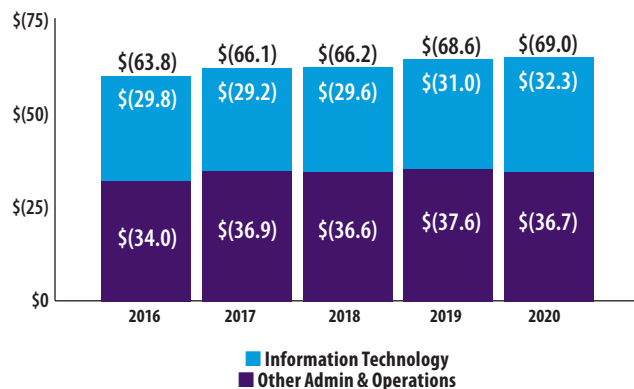
consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care. Net expenses increased by \$0.5 million in 2020, largely due 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

(in millions)	Revenues		Margin (expenses)	
	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**

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.

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		
Donor-restricted association equity	731.9	622.6
	0.1	1.6
Total association equity	732.0	624.2
	\$1,115.8	\$ 996.7

See accompanying notes to the consolidated financial statements.

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

OFFICERS AND
TRUSTEES

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Dr. Kridel

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
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 Michael Suk, MD, JD, MPH, MBA



Willie Underwood III, MD, MSc, MPH
 James L. Madara, MD



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.

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.

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.

Reference Committee G

BOT Report(s)

- 09 Preservation of the Patient-Physician Relationship
- 13 Amending the AMA's Medical Staff Rights and Responsibilities

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

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

1 INTRODUCTION

2
3 At the 2019 Annual Meeting Resolution 703-A-19, “Preservation of the Patient-Physician
4 Relationship,” was introduced by the Organized Medical Staff Section and referred by the House of
5 Delegates (HOD) for report back. The resolution asks our American Medical Association (AMA)
6 to identify perceived barriers to optimal patient-physician communication from the perspective of
7 both the patient and the physician, and to identify health care work environment factors that impact
8 a physician’s ability to deliver high quality patient care, including but not limited to: (1) the use
9 versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence
10 of a scribe during the patient-physician encounter.

11
12 This report discusses factors that contribute to patient-physician relationships and when those
13 factors can detract from the physician’s ability to provide high quality care or result in barriers to
14 communication that can threaten the patient-physician relationship. The AMA has dedicated
15 significant resources and effort to identifying and addressing the barriers to patient care and
16 effective patient-physician relationships, including the use of technology, documentation
17 requirements, prior authorization, and other work environment factors. This report will in part
18 describe those efforts and relevant outcomes.

19 20 BACKGROUND

21
22 The relationship between a patient and their physician is sacred. It requires trust, honesty, and
23 communication. As the healthcare industry has changed in recent decades, so have external factors
24 and internal dynamics that influence the patient-physician relationship. Both the patient’s and
25 physician’s roles and experiences have evolved, as well as their perceptions and expectations of the
26 communication and relationship with each other. Many factors contribute to the patient-physician
27 relationship, including electronic devices and documentation assistance such as scribes. Sometimes
28 these factors result in barriers to optimal communication that interfere with patient care. Barriers
29 created by technology, resource allocation, regulations, and other external factors can detract from
30 the communication and trust between physicians and their patients. These barriers often affect
31 patient health outcomes and/or the physician’s ability to provide high-quality care and experience
32 fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective
33 patient-physician communication is vital to preserving the special and trusted relationship between
34 physicians and their patients.

1 AMA POLICY

2
3 The AMA *Code of Medical Ethics* provides a definition of the patient-physician relationship that
4 exemplifies the spirit of this resolution. “The practice of medicine, and its embodiment in the
5 clinical encounter between a patient and a physician, is fundamentally a moral activity that arises
6 from the imperative to care for patients and to alleviate suffering. The relationship between a
7 patient and a physician is based on trust, which gives rise to physicians’ ethical responsibility to
8 place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound
9 medical judgment on patients’ behalf, and to advocate for their patients’ welfare” (*Code of Medical*
10 *Ethics* 1.1.1, “Patient-Physician Relationships”).

11
12 Health care technology has become integral to the practice of medicine and has improved many
13 aspects of patient care and the patient-physician relationship. The AMA recognizes the important
14 role technology has in modern health care and has established multiple policies to reflect this. For
15 example, the AMA supports the establishment of coverage, payment, and financial incentive
16 mechanisms to support the use of mobile health applications and associated devices, trackers, and
17 sensors by patients, physicians and other providers that support the establishment or continuation
18 of a valid patient-physician relationship (Policy H-480.943, “Integration of Mobile Health
19 Applications and Devices into Practice”). AMA policies support telemedicine as a mechanism to
20 deliver patient care and advocates for the widespread adoption of telehealth services in the practice
21 of medicine (Policy D-480.965, “Reimbursement for Telehealth” and Policy D-480.963, “COVID-
22 19 Emergency and Expanded Telemedicine Regulations”). The AMA *Code of Medical Ethics* also
23 make it clear that these technologies should not compromise or interfere with the patient-physician
24 relationship (AMA Code of Medical Ethics 1.2.12, “Ethical Practice in Telemedicine). It is AMA
25 policy that new communication technologies must never replace the crucial interpersonal contacts
26 that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms
27 of Internet communication should be used to enhance such contacts. The AMA provides detailed
28 guidelines for the appropriate and optimal use of email and text messages for communicating with
29 patients (Policy H-478.997, “Guidelines for Patient-Physician Electronic Mail and Text
30 Messaging”). The AMA *Code of Medical Ethics* also provides guidance for the ethical and
31 professional use of email and text message communications (Opinion 2.3.1, “Electronic
32 Communication with Patients”).

33
34 The AMA supports protecting the patient-physician relationship by advocating for the obligation of
35 physicians to be patient advocates; the ability of patients and physicians to privately contract; the
36 viability of the patient-centered medical home; the use of value-based decision making and shared
37 decision-making tools; the use of consumer-directed health care alternatives; the obligation of
38 physicians to prioritize patient care above financial interests; and the importance of financial
39 transparency for all involved parties in cost-sharing arrangements (Policy H-165.837, “Protecting
40 the Patient-Physician Relationship”). The AMA also supports: (1) policies that encourage the
41 freedom of patients to choose the health care delivery system that best suits their needs and
42 provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their
43 patients to the physician practice or hospital that they think is most able to provide the best medical
44 care when appropriate care is not available within a limited network of providers; and (3) policies
45 that encourage patients to return to their established primary care provider after emergency
46 department visits, hospitalization, or specialty consultation (Policy H-160.901, “Preservation of
47 Physician-Patient Relationships and Promotion of Continuity of Patient Care”).

48
49 Recognizing that government has a large influence on the practice of medicine, the AMA
50 continuously works to reduce the burden of government and third-party regulation on medical
51 practice and its intrusion into the patient-physician relationship and doctor-patient time (Policy

1 H-180.973, “The “Hassle Factor”). The AMA will continue these efforts, with additional focus on
2 the prescription of medication (Policy H-100.971, “Preserving the Doctor-Patient Relationship”).
3 Furthermore, the AMA endorses principles concerning the roles of federal and state governments
4 in the patient-physician relationship:

5
6 A. Physicians should not be prohibited by law or regulation from discussing with or asking
7 their patients about risk factors, or disclosing information to the patient (including proprietary
8 information on exposure to potentially dangerous chemicals or biological agents), which may
9 affect their health, the health of their families, sexual partners, and others who may be in
10 contact with the patient.

11 B. All parties involved in the provision of health care, including governments, are responsible
12 for acknowledging and supporting the intimacy and importance of the patient-physician
13 relationship and the ethical obligations of the physician to put the patient first.

14 C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and
15 advocacy are central to the delivery of evidence-based, individualized care and must be
16 respected by all parties.

17 D. Laws and regulations should not mandate the provision of care that, in the physician’s
18 clinical judgment and based on clinical evidence and the norms of the profession, are either not
19 necessary or are not appropriate for a particular patient at the time of a patient encounter
20 (Policy H-270.959, “AMA Stance on the Interference of the Government in the Practice of
21 Medicine”).

22
23 It is AMA policy that the relationship between physicians and their patients should not be disrupted
24 by direct communications from health plans to patients regarding individual clinical matters
25 (Policy H-140.919, “Doctor/Patient/Health Plan Communications”).
26

27 DISCUSSION

28
29 To appropriately respond to the resolution referred by the HOD, this report will focus on describing
30 the factors that contribute to patient-physician relationships, including:

- 31
32 • Shared decision-making
33 • Online health/medical information
34 • Health literacy
35 • Trust
36 • Implicit bias
37 • Adequate time
38 • Physical clinic setting
39 • Communication
40 • External influences
41

42 Barriers to communication and an effective patient-physician relationship can be encountered at
43 many points during the interactions between a patient and physician. Barriers can also manifest
44 from inherent attitudes or outward behaviors, of the patient and/or physician. Finally, barriers that
45 affect the quality of patient-physician interactions are often external environmental elements, such
46 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 themselves 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 care²⁵ 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.

Electronic Health Records

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:

1 I think, if used correctly, [the EHR] definitely improves communication and helps in terms of
2 patient care overall, with tracking what's going on with the patient. I think it's helped with
3 patient-to-physician communication.
4

5 Documentation requirements 6

7 Increasing documentation requirements from Medicare and commercial payers have also added to
8 physicians' administrative workload. A 2013 survey indicated 92 percent of medical residents and
9 fellows reported that documentation requirements were excessive.³⁷ Clinical documentation
10 requirements have increased over time with the mandated use of EHRs, increased quality reporting,
11 and increased demand for data. Much of the U.S. medical coding system is time-based,^{38, 39} which
12 has led to overemphasis on the amount of time spent with each patient and excessive focus on
13 "checking the boxes" to ensure documentation requirements are met. The Centers for Medicare and
14 Medicaid Services (CMS) recently enacted changes to the documentation requirements for
15 evaluation and management (E/M) services developed by the AMA's CPT Editorial Panel. These
16 changes will allow physicians to bill based on case complexity with less emphasis on the number
17 of minutes spent. Physicians will only be required to enter medically necessary information,
18 enabling them to spend more time connecting with their patient to collect high-value, relevant
19 information instead of redundant information. Further discussion on the Medicare E/M coding
20 changes and their anticipated benefits to the patient-physician relationship is presented in another
21 section of this report.
22

23 To reduce the burden of documentation during patient visits, many physicians employ the use of
24 documentation assistance tools or staff, such as speech recognition technology or medical scribes.
25 It has been found that access to documentation support, such as that of a medical scribe, can
26 increase the amount of direct face time with patients during a visit.¹⁶ Medical scribes work in a
27 variety of practice settings, including hospitals, emergency departments, physician practices, long-
28 term care facilities, ambulatory care centers, and others. In a 2015 retrospective comparative study,
29 physicians with medical scribes saw 9.6 percent more patients per hour than physicians without a
30 medical scribe.⁴⁰ Physicians who use medical scribes say they "feel liberated from the constant
31 note-taking that modern [EHRs] demand" and they can "think medically instead of clerically."⁴¹
32

33 When face-to-face time with the patient increases, physicians can listen and respond more
34 thoroughly without the distraction of entering data into the EHR, giving patients a better
35 experience. Physicians are in turn able to provide the level of care they find the most satisfying.¹⁶
36 There is evidence the use of speech recognition technology and medical scribes improves physician
37 satisfaction, including clinic, face time with patients, time spent charting, and accuracy and quality
38 of their charts.⁴² Patients also experience increased satisfaction with their physician visits when a
39 scribe is present to document for the physician. In one study of patients surveyed about their
40 physician's use of documentation assistance, 85 percent felt that having a scribe type notes for the
41 doctor improved the overall quality of their visit. Seventy-four percent also said that they would
42 like their other doctors to have scribes to type the exam notes.⁴³
43

44 The evidence available suggests that documentation assistance, whether through the use of speech
45 recognition technology or a medical scribe, can improve the communication and quality of visit
46 between patients and their physicians. Board of Trustees Report 20-A-17, "Study of Minimum
47 Competencies and Scope of Medical Scribe Utilization," provides additional information about the
48 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

1 eight EHR usability priorities, which outline and support the need for better usability,
2 interoperability, and access to data for both physicians and patients.⁵³ If followed, these priorities
3 will enable the development of higher-functioning, more efficient EHRs, contributing to a
4 reduction in the burden that EHR use places on patient care.

5
6 In 2019 the AMA established the Center for Health Equity to embed health equity into the
7 processes, practices, innovations, and performance of our AMA. This unit works to help the AMA
8 address issues that contribute to health disparities and inequity, including bias, stereotyping, and
9 prejudice, which can all inhibit a successful patient-physician relationship. By helping to reduce
10 these implicit influences, AMA enhances its ongoing work to preserve the integrity of physicians'
11 relationships with their patients.

12
13 Multiple collaborations are in place to help foster better EHR design and innovative health
14 information technology (HIT) solutions to help make the EHR user experience better and more
15 efficient. The AMA has established collaborations and partnerships with the organizations such as
16 SMART Initiative, AmericanEHR Partners, Carequality, Sequoia Project and Medstar Health's
17 National Center for Human Factors in Healthcare to help foster innovative HIT design
18 interoperability and transparent testing solutions which will to help ensure EHRs are designed and
19 implemented with physicians and patients in mind. The AMA Physician Innovation Network also
20 connects physician experts with industry innovators to facilitate the integration of the clinical voice
21 and the patient experience into HIT innovation. Finally, the AMA recently worked with various
22 industry stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification
23 framework which will help catalyze an industry-wide shift to higher-quality EHR systems that
24 enable better, more efficient use.

25
26 The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state
27 and specialty medical societies, national provider associations, and patient representatives to
28 develop a set of Prior Authorization and Utilization Management Reform Principles.⁵⁴ These
29 principles spurred conversations between health care professionals and insurers on the need for
30 prior authorization reform, which culminated in the release of the Consensus Statement on
31 Improving the Prior Authorization Process.⁵⁵ The consensus document reflects an agreement
32 between national associations representing both providers and health plans on the need to reform
33 prior authorization programs in multiple ways, including reducing the overall volume of prior
34 authorizations and advancing automation to improve transparency and efficiency. The AMA, in
35 addition to providing an evidence base demonstrating the need for prior authorization reform,
36 offers multiple resources to help physicians understand prior authorization laws and improve
37 processes within their practices.

38
39 The AMA and CMS in 2019 worked together to achieve the first overhaul of E/M office visit
40 documentation and coding in more than 25 years. Specifically, Medicare began to allow physicians
41 to document review and verification of history entered into the medical record in lieu of re-entering
42 the same information. For established patients, history and examination already contained in the
43 medical record no longer needs to be re-entered and physicians can document only what has
44 changed and relevant items that have not changed since the patient's last visit. The changes
45 implemented are a significant step in reducing administrative burdens that get in the way of patient
46 care and will allow physicians to spend more time with their patients, one of the key elements to a
47 meaningful patient-physician relationship. Considering the variation in patients, case complexity,
48 and specialty-specific needs, the AMA is not in favor of imposing a universal minimum time for
49 patient visits and supports these changes that enable physicians more flexibility determining the
50 appropriate amount of time to dedicate to their patients. The AMA is collaborating with the
51 University of California San Francisco to investigate changes in documentation and coding time,

1 perceived burden and physician burnout throughout the phases of the E/M coding changes. The
2 outcomes of this research will help institutional leaders and physicians identify additional
3 opportunities to reduce physician administrative burden and increase time spent with patients. This
4 research will also prioritize and inform advocacy efforts with federal (e.g., CMS) and state
5 regulators, commercial plans and EHR vendors to further address issues such as coding,
6 documentation. and burden reduction on behalf of physicians, their practices and patients.
7

8 The AMA during the COVID-19 pandemic has advocated for the expansion of and reimbursement
9 for telehealth so that patients can experience continuity of care and so physicians are adequately
10 compensated for their time providing remote patient care. The AMA's Digital Health
11 Implementation Playbook series offers comprehensive step-by-step guides to implementing
12 telehealth in practice.⁵⁶ Each Playbook offers key steps, best practices, and resources to support
13 implementation. The AMA continues to publish new guidelines and resources, as well information
14 about the latest updates on telehealth expansion amid COVID-19.
15

16 The AMA offers and continues to develop education modules that teach strategies and tactics to
17 help physicians save time on clerical and basic clinical tasks so that they have more time for
18 relationship-building and medical decision making with patients. Many of AMA's STEPS
19 Forward™ modules address some aspect of organizational culture or practice efficiency to help
20 physicians optimize their patient relationships, including several that aim to help practices save
21 time, communicate more effectively, and improve patient and provider satisfaction.
22

23 The AMA's ongoing work to reduce physician burnout strives to remove the obstacles and burdens
24 that interfere with patient care or hinder communication with patients. This work includes the
25 AMA Practice Transformation Initiative (PTI), which supports researchers in building evidence on
26 effective interventions to reduce burnout and increase physician satisfaction within their health
27 systems. Interventions implemented through the PTI include measures to enhance the roles of non-
28 provider care team members to reduce administrative burden for physicians, and to gain
29 efficiencies in physician time. Other interventions aim to help clinicians maximize their practice
30 efficiency, promote self-care, and address sources of burnout and stressful workplace situations.
31 The AMA also offers institutional assessments to help organizations measure burnout among their
32 physician staff, implement improvements, and develop evidence-based support systems within
33 their practices, reducing burnout and improving physicians' ability to provide high-quality patient
34 care. In addition, the AMA offers a guideline, "Collaborative communication strategies: Partner
35 with patients," to help clinicians communicate clearly and effectively with patients, particularly
36 about treatment adherence which is one of the key elements of a successful patient-physician
37 relationship.⁵⁷
38

39 CONCLUSION

40

41 Many factors contribute to the dynamics of a relationship between a patient and physician,
42 including shared decision-making, online health and medical information, health literacy, trust,
43 implicit bias, physical settings, communication, and external influences. These factors have been
44 studied and written about at length. The evidence shows that patients and physicians both have
45 better experiences when they feel they have adequate time for talking and making decisions about
46 treatment together. Physicians have better experiences when they have assistance with
47 documentation so they can spend more of their visit face-to-face with their patients rather than
48 looking at the computer. Physicians are more satisfied with their patient relationships when patients
49 trust them. Patients are more satisfied with their clinic visits and their physicians when they feel
50 they have been listened to and allowed to talk about their concerns. Improving communication and

1 preventing implicit biases from influencing care decisions are ways both physicians and patients
2 can ensure their relationships with one another are healthy, trusting, and productive.

3
4 Considering the volume and range of published literature about the barriers to patient-physician
5 relationships identified in Resolution 703-A-19 and discussed in this report, it is not recommended
6 that additional formal research be undertaken by the AMA. The AMA will continue to dedicate
7 significant resources to helping physicians overcome these barriers to enhance and preserve their
8 relationships with their patients.

9
10 RECOMMENDATION

11
12 The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be
13 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

1 At the November 2020 Special Meeting, the House of Delegates (HOD) referred Resolution 710,
2 "A Resolution to Amend the AMA's Physician and Medical Staff Bill of Rights." Resolution 710
3 was sponsored by the Medical Society of Virginia and instructed the AMA to amend Policy
4 H-225.942, "Physician and Medical Staff Member Bill of Rights," to add new text to the preamble
5 as shown below:

6
7 Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

8
9 Preamble

10
11 The organized medical staff, hospital governing body and administration are all integral to the
12 provision of quality care, providing a safe environment for patients, staff and visitors, and
13 working continuously to improve patient care and outcomes. They operate in distinct, highly
14 expert fields to fulfill common goals, and are each responsible for carrying out primary
15 responsibilities that cannot be delegated.

16
17 The organized medical staff consists of practicing physicians who not only have medical
18 expertise but also possess a specialized knowledge that can be acquired only through daily
19 experiences at the frontline of patient care. These personal interactions between medical staff
20 physicians and their patients lead to an accountability distinct from that of other stakeholders in
21 the hospital. This accountability requires that physicians remain answerable first and foremost
22 to their patients.

23
24 Medical staff self-governance is vital in protecting the ability of physicians to act in their
25 patients' best interest. Only within the confines of the principles and processes of self-
26 governance can physicians ultimately ensure that all treatment decisions remain insulated from
27 interference motivated by commercial or other interests that may threaten high-quality patient
28 care.

29
30 The AMA recognizes the responsibility to provide for the delivery of high quality and safe
31 patient care, the provision of which relies on mutual accountability and interdependence with
32 the health care organization's governing body, and relies on accountability and inter-
33 dependence with government and public health agencies that regulate and administer to these
34 organizations.

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 Resolution 710-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

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

1 Whereas, More than 70 percent of consumers search for health information online, according to
2 Pew Research Center, and 77 percent of consumers say they use online reviews as the first
3 step in finding a new physician*; and
4

5 Whereas, Online reviews are an open public forum that allows patients to share their stories and
6 photos regarding their experiences with doctors; and
7

8 Whereas, Often these reviews are negative and accuse the doctors of complications or
9 mismanagement of medical visits, treatments and procedures that they have had; and
10

11 Whereas, Bad online ratings can wreak havoc on doctors' businesses, in extreme cases driving
12 physicians to leave a state to practice elsewhere; and
13

14 Whereas, Ratings sites will take down reviews that use profanity or can be proven fake, but they
15 typically won't edit or remove a review simply because a doctor (or any business) disputes what
16 is in it; and
17

18 Whereas, Critics of public airing of patient comments argue that it puts a doctor in an untenable
19 position because federal privacy laws such as HIPAA prohibit doctors from compromising
20 patient confidentiality by responding directly to a patient's complaint, leaving physicians with
21 limited ability to rebut complaints; and
22

23 Whereas, Physicians are uniquely vulnerable to public criticism and potential adverse publicity
24 regarding their professional abilities and find this extremely unfair and unjust; and
25

26 Whereas, Change.org (a petition website operated by for-profit Change.org, Inc., which hosts
27 sponsored campaigns for organizations and serves to facilitate petitions by the general public)
28 has posted a petition signed by over 42,000 physicians calling for an immediate end to online
29 reviews of ALL doctors and providers who are subject to HIPAA and medical privacy laws,
30 stating further that reviews should not be posted until physicians can defend themselves or
31 respond; and
32

33 Whereas, The problem of addressing unfair online reviews is faced by physicians throughout
34 the country transcending regions and states; therefore be it
35

36 RESOLVED, That our American Medical Association take action that would urge online review
37 organizations to create internal mechanisms ensuring due process to physicians before the
38 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

1 Whereas, Employed physician contracts contain clauses to the effect that the physician
2 maintains privileges ONLY if the physician remains employed by the hospital/health system; and
3

4 Whereas, An employed physician due to circumstances beyond the physician's control could be
5 dismissed and upon that dismissal, lose all privileges despite having been credentialed
6 according to hospital/health system bylaws; and
7

8 Whereas, Hospital medical staff bylaws ensure rights and due process for all members of the
9 medical staff; therefore be it
10

11 RESOLVED, That our American Medical Association advocate in support of all employed
12 physicians receiving all rights and due process protections afforded all other members of the
13 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

1 Whereas, The US Centers for Medicare and Medicaid Services (CMS) has been publishing
2 mortality data of hospitalized patients since 2008; and
3

4 Whereas, Public reporting has been expanded to cover multiple quality measures by many
5 entities over the past few years; and
6

7 Whereas, The debate rages over whether to focus on outcomes versus care processes when
8 assessing quality; and
9

10 Whereas, The validity of outcomes measures is under scrutiny when the data used for reporting
11 purposes is claims data; and
12

13 Whereas, Any models that are used for assessing quality should be reliable and valid; and
14

15 Whereas, Models using data on severity of illness consistently outperform models using only
16 comorbidity data; and
17

18 Whereas, Factors associated with severity of illness are the strongest predictors of quality; and
19

20 Whereas, Data from hospital billing systems contain no factors associated with the severity of
21 illness; and
22

23 Whereas, Because of the variability of information in the medical record, claims data cannot
24 reliably code comorbid conditions; and
25

26 Whereas, It is time to eliminate measures based on claims data from public reporting and other
27 programs designed to hold physicians and hospitals accountable for improving outcomes;
28 therefore be it
29

30 RESOLVED, That our American Medical Association collaborate with the US Centers for
31 Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician
32 and hospital quality measures are based on the delivery of care in accordance with established
33 best practices (Directive to Take Action); and be it further
34

35 RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of
36 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>

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

Report of the Speakers

- 01 Recommendations for Policy Reconciliation

REPORT OF THE BOARD TRUSTEES

B of T Report 02-JUN-2021

Subject: 2020 Grants and Donations

Presented by: Russ Kridel, MD, Chair

-
- 1 This informational financial report details all grants or donations received by the American
2 Medical Association during 2020.

**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		<u>850</u>
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		<u>335</u>
Total Grants and Donations		\$ <u><u>1,185</u></u>

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.

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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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 Citizen 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 Creskide 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

1 Policy G-605.050, “Annual Reporting Responsibilities of the AMA Board of Trustees,” calls for
2 the Board of Trustees to submit a report at the American Medical Association (AMA) Annual
3 Meeting each year summarizing AMA performance, activities, and status for the prior year.

4 5 INTRODUCTION

6
7 The AMA’s mission is to promote the art and science of medicine and the betterment of public
8 health. As the physician organization whose reach and depth extends across all physicians, as well
9 as policymakers, medical schools, and health care leaders, the AMA is uniquely positioned to
10 deliver results-focused initiatives that enable physicians to answer a national imperative to
11 measurably improve the health of the nation.

12 13 *Representing physicians with a unified voice*

14
15 AMA worked closely with the White House, Congress, state lawmakers and a range of federal and
16 state agencies to ease the public health and economic consequences of COVID-19. We secured
17 nearly \$180 billion in emergency funding for physician practices and health systems to help
18 recover from the financial devastation of COVID-19 and continue to provide critical care to
19 patients.

20
21 AMA pushed the federal government to accelerate production of life-saving PPE for physicians
22 and frontline workers, improve and expand testing capabilities, and revise guidelines for
23 serological and antibody testing.

24
25 AMA worked in federal court to protect international medical graduates, as well as physicians and
26 medical students with Deferred Action for Childhood Arrivals – or DACA -- status. AMA joined
27 32 other leading health organizations in filing a successful amicus brief to ensure the U.S. Supreme
28 Court upheld the DACA program that has richly benefitted the medical community. AMA now
29 serves as a plaintiff in three federal cases, including one that the U.S. Supreme Court has agreed to
30 review next fall involving the Title X program. In addition, AMA has filed friend of the court
31 briefs in state and federal courts around the country on a wide range of critical issues, from
32 LGBTQ health to tort reform, unfair insurer practices to physician free speech rights, tobacco
33 control to patient access to care, with more than 80 briefs filed in 2020 alone.

34
35 Throughout the pandemic, the AMA COVID-19 Resource Center was a trusted source of clear,
36 evidence-based guidance throughout the year. Features included daily video updates, action plans,
37 quick-start telehealth guides, care for caregivers and more.

38
39 AMA launched a physician-focused webinar series with federal health officials that explored the
40 COVID-19 vaccine development process and rollout. We also launched a comprehensive campaign

1 across multiple platforms and channels to build confidence in the safety and efficacy of the new
2 vaccines among physicians, other health care professionals and patients.

3
4 AMA supported the year-end omnibus package which avoided major Medicare cuts for most CPT
5 codes, deferred reinstatement of the Medicare sequester, and secured major modifications in
6 surprise billing legislation that originally would have allowed insurers to avoid responsibility to
7 have meaningful networks.

8
9 AMA's communications strategy achieved a record 115 billion media impressions in 2020, through
10 nearly 80,000 stories which included 115 national TV interviews and generated \$1.1 billion in
11 estimated advertising value equivalent for the AMA.

12
13 *Removing obstacles that interfere with patient care*

14
15 AMA worked with the Centers for Medicare & Medicaid Services to reduce physician
16 documentation relating to Evaluation and Management reporting requirements, the first such
17 overhaul of E/M codes in more than 25 years.

18
19 AMA continued to work at the state and national levels to push for important prior authorization
20 and step therapy reforms across the U.S., keeping the focus on reducing the volume of prior
21 authorization requirements and its impact on patients care.

22
23 AMA introduced a new Coping with COVID-19 for Caregivers assessment survey to help
24 organizations measure and address the unique demands of the pandemic on their staffs. In 2020,
25 over 80 health care systems from 30 states deployed the assessment resulting in more than 50,000
26 individual responses. The data findings were compiled into a national COVID-19 comparison
27 report for organizations to compare their survey results to national benchmarks. AMA compiled a
28 guide with practical strategies for health system leadership to consider in support of their
29 physicians and care teams and conducted a COVID-19 Roundtable for shared learning among
30 health system leaders.

31
32 AMA's STEPS Forward™ portfolio expanded with 12 new and 19 updated toolkits, educational
33 modules, videos, podcasts customizable resources to help physicians and their teams streamline
34 their workflows for improved patient care.

35
36 AMA developed a checklist that provided physicians and administrators with guidance and
37 strategies on controlling labor costs and information about stimulus relief considerations and legal
38 compliance during the pandemic.

39
40 AMA's guide to Creating a Resilient Organization offered 17 steps to caring for health care
41 workers before, during and after COVID-19, providing practical tips on coping during times of
42 acute stress, lowering the incidence of chronic stress illness and injury.

43
44 Supporting physicians' mental health needs, AMA launched a Behavioral Health Integration
45 Collaborative in partnership with leading medical societies to provide practical steps to blend
46 medical and behavioral health services with primary care.

47
48 *Leading the charge to confront public health crises*

49
50 AMA's Center for Health Equity helped lead a national conversation about the pandemic's
51 disproportionate impact on communities of color, the importance of accurate, nationwide data

1 collection, and advanced policies that decrease inequities, supported equitable access to care and
2 research, and improve culturally competent care.

3
4 AMA responded to dire shortages of personal protective equipment by helping secure hundreds of
5 thousands of PPE for AMA physician members through a creative new collaboration with Project
6 N95, a non-profit national clearinghouse for medical supplies.

7
8 The Current Procedural Terminology (CPT) Team issued 24 new or revised codes supporting
9 COVID-19 care, guides and tools that were the most-downloaded documents from the AMA
10 COVID-19 Resource Center.

11
12 The JAMA Network COVID-19 Resource Center provided access to a wealth of scientific
13 resources on COVID-19 diagnosis and treatment, with a focus on information physicians could
14 share with patients and their families. Expanded livestream and podcast portfolios contributed to a
15 40% surge in online traffic across the JAMA Network in 2020, representing some 190 million
16 engagements.

17
18 Rapidly expanded video programming across AMA digital platforms, including 200 episodes of the
19 popular daily AMA COVID-19 Update, resulted in a 900% increase in video minutes viewed in
20 2020.

21
22 More than 6.2 million users consumed nearly 10 million pages of content from the COVID-19
23 Resource Center, including more than 380,000 downloads of the 60 available guides for health care
24 professions. The record 20 million unique visitors to the AMA website exceeded the combined
25 total for both 2018 and 2019.

26
27 AMA partnered with American Heart Association and others on a national campaign to promote
28 better heart health in Black women. The Release the Pressure campaign created culturally relevant
29 resources to help Black women prioritize their blood pressure control and other aspect of self-care.

30
31 AMA collaborated with NORC at the University of Chicago to develop criteria for determining
32 validated self-measured blood pressure devices and introduced a MAP blood pressure dashboard.
33 The AMA MAP BP™ program and dashboard provides health care organizations a visual
34 representation of their performance on five key blood pressure metrics, including stratification by
35 ethnicity, race, and gender. The AMA MAP BP™ program and dashboard demonstrates a 10-
36 percentage point increase in BP control in six months with sustained results at one year.

37
38 Only in its second year, the AMA's Enterprise Social Responsibility (ESR) program continues to
39 deliver an organized and thoughtful structure to engage AMA employees in public service work
40 aligned with the organization's values and goals. The program has strategically integrated within
41 the OneAMA culture aligning "give back" opportunities at employee events and partnering with
42 employee resource groups. Thirty-nine percent of AMA employees, representing every office
43 location, logged over 2,500 volunteer hours, supported over 90 organizations and fundraised over
44 \$60,000.

45
46 *Driving the future of medicine*

47
48 AMA built upon strategic efforts to advance telehealth and improve physician well-being and
49 practice sustainability during COVID-19 by developing dozens of free, online resources to help
50 physicians better manage their mental health, keep their practices afloat, and foster widespread

1 adoption of remote patient care through the Telehealth Initiative, the Telehealth Implementation
2 Playbook and accompanying resource guide.

3
4 The AMA successfully launched a new initiative for the AMA Masterfile, which integrates data
5 from over 124 data sources and improves the clarity of race and ethnicity data.

6
7 AMA's Integrated Health Model Initiative (IHMI) received recognition within the digital health
8 community for work in developing Social Determinants of Health (SDoH) and data standards and
9 promoting interoperability. Rock Health selected AMA as top non-profit in digital health.

10
11 The AMA worked diligently to meet the needs of the medical education community during
12 COVID-19. AMA developed the comprehensive AMA MedED COVID-19 resource guide as a
13 centralized location to assist our educators, residents and students in keeping up with new
14 information and providing resources, links and a community discussion forum. AMA produced a
15 series of webinars addressing COVID-19's impact on medical education and produced guidelines
16 for trainees and others practicing in the pandemic.

17
18 The AMA Accelerating Change in Medical Education Consortium and Reimagining Residency
19 Initiative held a highly successful inaugural GME Innovation Summit virtually in October, with
20 more than 400 attendees and over 200 presentations, workshops and posters. It included a shark-
21 tank style Innovations Challenge, which resulted in the award of three new AMA GME
22 Innovations grants.

23
24 The JAMA Network launched JAMA Health Forum, an online channel that addresses health policy
25 and health strategy issues affecting medicine and health care, combining curated content from
26 across the JAMA Network with weekly blog posts by leaders in health policy.

27
28 Health, Science and Ethics made significant strides in advancing the AMA's precision medicine
29 work in 2020. Accomplishments include convening a cross-business unit collaborative team to
30 align on strategy and implementation, partnering with the American Society of Health-System
31 Pharmacists to develop a virtual summit series focused on the emerging area of pharmacogenomics
32 and gathering data through physician surveys and environmental scans to inform future initiatives.

33
34 *AMA Journal of Ethics* received nearly four million annual visits. To help individuals and
35 organizations navigate ethical challenges wrought by the pandemic, the journal established a
36 COVID ethics resource center with new multimedia CME. While the pandemic disrupted much of
37 normal life including the start of another medical school year, thousands of new students received a
38 pocket edition of the *AMA Code of Medical Ethics* and possibly their first education of AMA's role
39 in advancing the ethics of a profession.

40
41 AMA partnered with CDC on Project Firstline, a collaborative of diverse healthcare and public
42 health partners that aims to provide engaging, innovative, and effective infection control training
43 for frontline healthcare workers and members of the public health workforce. Project Firstline's
44 innovative content is designed so that health care personnel can understand and confidently apply
45 the infection control principles and protocols necessary to protect themselves, their facility, their
46 family, and their community from infectious disease threats, such as COVID-19. Project Firstline
47 content will be featured on the AMA Ed Hub™.

48
49 AMA Ed Hub™ expanded its offerings to feature courses on COVID-19, infection prevention and
50 control, health equity, and physician burnout and wellness, contributing to a near 65% growth in
51 views over 2019.

1 AMA's portfolio of education on AMA Ed Hub™ expanded to include more education from JN
2 Learning, the *AMA Journal of Ethics* and *Code of Medical Ethics*, AMA Health Systems Science,
3 AMA Steps Forward and CPT. Sixteen organizations have signed on to highlight their education on
4 AMA Ed Hub with 6 new organizations launched in 2020 – including Obesity Medicine
5 Association, Stanford Center for Continuing Medical Education, Howard Brown Health, Society of
6 Hospital Medicine Education, American Society of Addiction Medicine and The Jackson
7 Laboratory.

8
9 The AMA Center for Health Equity (CHE) worked to embed equity across the enterprise and
10 throughout medicine by being among the first to call out the pandemic's missing data through a
11 NY Times OpEd and Oprah-Apple TV. CHE launched the Prioritizing Equity Series, published a
12 COVID-19 Latinx Report and established the Health Equity Resource Center on the AMA Ed Hub.
13 AMA incorporated a diversity, equity and inclusion lens for all convened groups to support our
14 work, including the CPT Editorial Panel, and developed training to better integrate health equity
15 across the organization. AMA began training staff through Racial Equity Institute's phase one
16 program, with plans to broaden the training across all staff in the months ahead.

17
18 AMA made a \$1 million investment in a Chicago-based collaborative that focuses on addressing
19 social determinants of health in an area of the city where life expectancy is far below the national
20 average. The AMA will invest \$2 million total over two years.

21 22 *Membership*

23
24 All the ways AMA supported physicians in 2020 contributed to another strong financial
25 performance and a six percent membership surge, the 10th consecutive year of growth.

26 27 *EVP Compensation*

28
29 During 2020, pursuant to his employment agreement, total cash compensation paid to James L.
30 Madara, MD, as AMA Executive Vice President was \$1,185,918 in salary and \$1,292,221 in
31 incentive compensation, reduced by \$2,462 in pre-tax deductions. Other taxable amounts per the
32 contract are as follows: a \$182,308 payment of prior years' deferred compensation, \$23,484
33 imputed costs for life insurance, \$24,720 imputed costs for executive life insurance, \$2,755 paid
34 for parking and \$3,500 paid for an executive physical. An \$81,000 contribution to a deferred
35 compensation account was also made by the AMA. This will not be taxable until vested and paid
36 pursuant to provisions in the deferred compensation agreement.

37
38 For additional information about AMA activities and accomplishments, please see the "AMA 2020
39 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

1 This report summarizes trends and news on tobacco usage, policy implications, and American
2 Medical Association (AMA) tobacco control advocacy activities from March 2020 through
3 February 2021. The report is written pursuant to AMA Policy D-490.983, “Annual Tobacco
4 Report.”

5 6 TOBACCO USE AND COVID-19

7
8 Early studies have linked certain underlying medical conditions with an increased risk for severe
9 illness from the virus that causes COVID-19. The Centers for Disease Control and Prevention
10 (CDC) publish an ongoing list of conditions for which sufficient evidence indicates the conditions
11 are likely to cause or may cause more severe outcomes in adults with COVID-19. CDC includes
12 smoking as a condition likely to increase COVID-19 severity, which has resulted in some states
13 such as Illinois adding current/former smokers to vaccine priority status.

14
15 A literature review in *Respiratory Medicine* found that tobacco use in all forms, whether smoking
16 or chewing, is significantly associated with severe COVID-19 outcomes. According to the authors,
17 pre-existing comorbidities in tobacco users such as cardiovascular diseases, diabetes, respiratory
18 diseases, and hypertension were found to further aggravate the virus making the treatment of such
19 COVID-19 patients more challenging due to their rapid clinical deterioration. The authors
20 conducted the literature review from August to September 2020.

21 22 TOBACCO USE AND HEALTH EQUITY

23 24 Study Looks at Menthol Cigarettes with a Social Justice Lens

25
26 Menthol could be exacerbating deep social inequities according to a paper published in *Nicotine &*
27 *Tobacco Research*. Researchers at Columbia University Mailman School of Public Health and
28 colleagues at CUNY and Rutgers School of Public Health suggest that a ban on menthol cigarettes
29 could have monumental implications for both short- and long-term physical and mental health of
30 communities of color. In 2009 the FDA banned cigarettes with certain flavors that appeal to
31 children and teens such as bubblegum and chocolate. The FDA did not include menthol in that
32 2009 action stating it would be conducting more research, which FDA completed in 2011. FDA’s
33 scientific committee concluded that menthol in cigarettes increases initiation, facilitates
34 progression to regular smoking, increases dependence, and decreases the likelihood of smoking
35 cessation, especially among both youth and adult Black smokers, and as such, the removal of
36 menthol from cigarettes would benefit public health. Overall estimates indicate that if menthol was
37 included in the flavored cigarette ban, over 630,000 deaths would be averted, of which one of three
38 would be a Black life. Despite the committee’s conclusions, FDA has not taken action to ban
39 menthol.

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

1 in part to the e-cigarette industry marketing the use of nicotine salts instead of freebase nicotine.
2 Freebase nicotine is used in most other e-cigarette cartridges, or vaping, products and conventional
3 tobacco products (e.g., cigarettes). According to the study, nicotine salts, which have a lower pH
4 than freebase nicotine, allow particularly high levels of nicotine to be inhaled more easily and with
5 less irritation to the throat than freebase nicotine. The most commonly sold pod mod brand is
6 JUUL, which accounted for 75% of all U.S. e-cigarettes sales by the end of 2018. A majority
7 (59.1%) of U.S. high school student e-cigarette users report JUUL is their usual brand.
8

9 Continued monitoring of e-cigarette sales and use is critical to inform strategies to minimize risks.
10 As part of a comprehensive approach, such strategies could include those that address product
11 innovations and flavors that appeal to youth.
12

13 *Prevalence and Trends in Cigarette Smoking Among Adults with Epilepsy - United States, 2010–*
14 *2017.*
15

16 Studies have shown that cigarette smoking is as common, and sometimes more so, among adults
17 with a history of epilepsy compared with those without a history of epilepsy. According to the
18 prevalence report in the November 27, 2020 MMWR, citing the latest available data, from 2010–
19 2017, one in four adults with active or inactive epilepsy were current smokers, compared with one
20 in six persons without epilepsy. Compared with adults without epilepsy, adults with epilepsy report
21 lower household income, more unemployment and disability, worse psychological health, and
22 reduced health-related quality of life. This report is the first assessment of smoking trends in people
23 with epilepsy. While cigarette smoking declined significantly among adults without a history of
24 epilepsy, from 19.3% in 2010 to 14.0% in 2017, declines in current cigarette smoking among adults
25 with active epilepsy were not statistically significant (from 26.4% to 21.8%). This lack of a
26 significant decrease in people with epilepsy provides an intervention opportunity. Health and social
27 service providers who interact with persons with active epilepsy should ensure that smoking
28 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

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 Keays, 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](#).

1 Drs. Derige and Lemos were also deeply instrumental in producing The AMA Latinx Health
2 Inequities Report, which reports on Latinx ethnic data and uncovers the true magnitude of
3 COVID-19 on the Latinx community.
4

5 (8) Another notable accomplishment has been the creation of the AMA internal Language Access
6 Plan, also led by CHE staff. The Language Access Plan includes best practices and guidance to
7 support an inclusive AMA policy to ensure access under Language Access Obligations Under
8 Executive Order 13166 and meaningful access for limited English proficient persons under the
9 national origin nondiscrimination provisions of Title VI of the 1964 Civil Rights Act. Our
10 [AMA Health Equity Initiatives Webpage](#) went live in September 2020. It features content from
11 healthcare, governmental and community organizations across the country that are working to
12 provide resources to minoritized and marginalized populations, dismantling racist systems and
13 improving patient trust in the health care system. The CHE partnered with these organizations
14 to collect their insights to help our AMA better understand the history of the project or
15 initiatives, the overall goals of the projects and initiatives, the expected results and early wins,
16 as well as the key partners involved in the effort.
17

18 (9) In November 2020, the CHE hired Gina Hess as Operations Assistant. Amongst other pertinent
19 organizational capacity work, Ms. Hess tracks the CHE team's information for presentations,
20 keynotes, and panels, and co-coordinates the bi-weekly Prioritizing Equity Series with Aziza
21 Taylor, CHE's Communications and Marketing Manager, and with the Digital Strategy and
22 Operations team of Enterprise Communications.
23

24 The equity work of the AMA has greatly benefitted from burgeoning health equity leaders,
25 including CHE interns. In six months time (May-November 2020) the first CHE intern, Brian
26 De La Cruz, a graduate student from Wheaton College, was instrumental in the early
27 organization and execution of the Prioritizing Equity series. He built a database for Prioritizing
28 Equity series records, which reflect not only the date and time specifics of the YouTube series
29 but also its episode panelists, viewership statistics and social media impact. Mr. De La Cruz
30 also supported the CHE Performance and Operations, and Marketing and Communications
31 teams to help create a workflow for processing the Prioritizing Equity honoraria for guest
32 speakers, and helped to revamp the CHE Sharepoint site.
33

34 The CHE collaborated with the AMA Federation Relations team to engage with the Federation
35 of Medicine on December 2, 2020. Dr. Maybank presented on the mission and goals of the
36 CHE as well reporting on recent activities and plans for 2021. The plans include a deeper and
37 sustained engagement with Federation members through regularly scheduled meetings where
38 Federation members may highlight their health equity activities with each other and potentially
39 collaborate on common efforts.
40

41 (10) Starting in 2020 and continuing into 2021, CHE has contributed expertise to the google.org-
42 backed Health Equity Task Force convened by Dr. Daniel Dawes, Satcher Health Institute. The
43 Task Force is guiding the creating of a public-facing health equity tracker, with the goal of
44 providing accessible and impactful data to a wide range of users. CHE staff represented two
45 different subcommittees within the Task Force—the Data Consortium and the Population-
46 Based Strategies Work Group.
47

48 (11) As the year came to a close, the CHE continued to expand the equity presence and visibility of
49 the AMA. Since 2020, CHE staff have delivered keynotes and moderated panel conversations
50 close to 160 in number. Table 3 in the Appendix outlines these events.

1 1st Quarter, 2021

2 January 2021 brought with it upheaval with the siege of the nation's Capitol building, and
 3 ongoing suspicions of threat to the country's symbol of democracy. At the same time, the
 4 change in the presidential administration offers opportunities to centering health equity at the
 5 national stage. This season of change requires physician-advocate leadership—leadership
 6 which the AMA through the CHE and other business units, is creating through various
 7 physician-supporting programs.

- 8
- 9 (1) Referred to in the first CHE BOT Report as the Health Equity Advocacy and Leadership
 10 (HEAL) Fellowship, the AMA and Morehouse School of Medicine Satcher Health Leadership
 11 Institute's [Medical Justice and Advocacy Fellowship](#) is underway. The Medical Justice in
 12 Advocacy Fellowship is a collaborative educational initiative to empower physician-led
 13 advocacy that advances equity and removes barriers to optimal health for marginalized people
 14 and communities. The fellowship will mobilize physicians to be part of the next generation of
 15 advocacy leaders, driving meaningful policy and structural changes that produce equity and
 16 justice in the communities they serve. By July 2021, it will have selected its first 10-member
 17 cohort. Diana Derige, and several other CHE staff, coordinated the internal AMA team—
 18 including staff from Advocacy, Ed Hub, Marketing and Member Experience (MMX),
 19 Improving Health Outcomes (IHO), Medical Education, Health and Science, and Payment and
 20 Quality, to see this vast effort into fruition.
- 21
- 22 (2) The Women's Equity and Leadership program (WEL) will foster the development of the next
 23 wave of female physician leaders to build a healthier, more equitable work experience. WEL is
 24 a collaboration of ten health care organizations: the American Academy of Pediatrics
 25 (administrator), American Academy of Family Physicians, American College of Physicians,
 26 American College of Obstetricians and Gynecologists, American Hospital Association,
 27 American Medical Association, American Medical Women's Association, American
 28 Psychiatric Association, National Hispanic Medical Association, and National Medical
 29 Association, who will each contribute 5 participants to the 2021 cohort (total 50.)
- 30
- 31 (3) The CHE advances the AMA's commitment and cause to making plain and accessible the
 32 significance of equity in health, using myriad multi-media platforms. In continued
 33 collaboration with the Marketing and Member Experience (MMX) BU, the CHE commenced
 34 Season 2 of "Prioritizing Health Equity," on the AMA's YouTube channel. To date, 26
 35 episodes have been produced, with more than 137,000 views. While the intent of the series
 36 remains unchanged since its inception, the co-producing business units vary each episode not
 37 only in subject focus, but also by episode length, at either 30 minutes, 45 minutes, or 1-hour.
 38 Table 5 reflects the AMA Prioritizing Equity episodes to date, listed from most recent to most
 39 dated.

40

41 Table 4 of the Appendix lists the books, research papers, and other notable publications
 42 produced by CHE staff, over the last year. These include a book, *Unequal Cities: Structural*
 43 *Racism and the Death Gap in America's 30 Largest Cities*, published by the Johns Hopkins
 44 University Press as part of its "Health Equity in America" series. CHE members have also co-
 45 authored articles in leading scholarly journals, including the *Lancet*, *Health Affairs*, *JAMA*
 46 *Network Open*, the *American Journal of Preventive Medicine*, and *Public Health*.

47

48 In progress are an edited book on structural competency and the COVID-19 pandemic (co-
 49 edited by Aletha Maybank, Fernando De Maio, Jonathan Metzl and Uché Blackstock) and an
 50 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

1 improvement in the process. The plan is aligned with the Center for Health Equity's five
2 strategic approaches: embed equity; build alliances and share power; ensure equity in
3 innovation; push upstream; and create pathways for truth, racial healing, reconciliation, and
4 transformation.

5
6 2nd Quarter, 2021 and 3rd Quarter 2021 Projections

7 (1) The Board's first report to the House of Delegates on the CHE gave the early outline for what
8 will henceforth be referred to as the Centering Equity in Emergency Preparedness and
9 Response Recovery Initiative for Healthcare (the CEEPRR). The CEEPRR is created in
10 partnership between our AMA and confirmed partners, including the Planned Parenthood
11 Federation of America (PPFA), American College of Preventive Medicine (ACPM), American
12 Public Health Association (APHA), National Medical Association (NMA), National Hispanic
13 Medical Association (NHMA), GLMA, American Association of Public Health Physicians,
14 America's Essential Hospitals, American Academy of Family Physicians, and the National
15 Birth Equity Collaborative. The CEEPRR will serve as a resource for healthcare professionals
16 and for healthcare organizations to embed and implement equity strategies and tactics to
17 prepare and respond to emergencies. There is a dearth of guidance and community in
18 healthcare in this domain. The initial product will include a guide/playbook with guiding
19 principles, critical shared terminology, and illustrative case studies. There will be opportunities
20 to extend this asset via other amplifying opportunities such as the Ed Hub. The CHE is using a
21 collaborative approach to inform product development, innovation, and amplification. This
22 initiative will be the first of its kind and a unique opportunity to promote and establish more
23 equitable policies, practices and service behaviors across healthcare. The anticipated release
24 date is for May 2021.

25
26 (2) The "Ensure equity in innovation" strategy will continue to be developed with the guidance of
27 the AMA External Equity & Innovation Advisory Group and through market research and
28 stakeholder engagement that centers the voices of patients, innovators, and investors from
29 historically marginalized and minoritized communities. This research and stakeholder
30 engagement will inform collaborative strategic initiatives and policies, internal training and
31 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

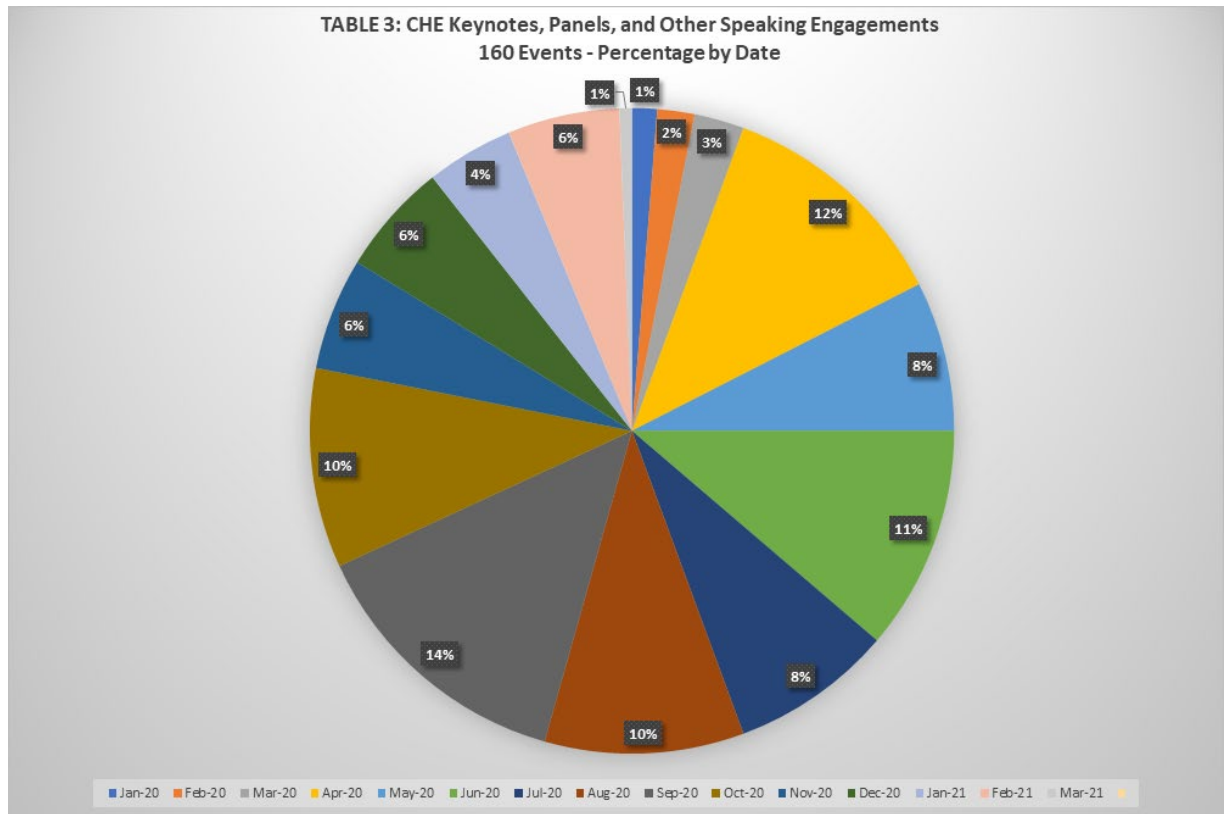


TABLE 4: CHE Peer-Reviewed Publications

<u>AUTHORS</u>	<u>YEAR</u>	<u>TITLE</u>	<u>JOURNAL</u>
<u>Metzl, Maybank, and De Maio</u>	<u>2020</u>	<u>Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System</u>	<u>JAMA</u>
<u>Crear-Perry, Maybank, Keelys, Mitchell, and Godbolt</u>	<u>2020</u>	<u>Moving towards anti-racist praxis in medicine</u>	<u>Lancet</u>
<u>Schober, Hunt, Benjamins, Silva, Saiyed, De Maio, and Homan</u>	<u>2020</u>	<u>Homicide Mortality Inequities Across the 30 Biggest Cities in the United States</u>	<u>American Journal of Preventive Medicine</u>
<u>Bishop-Royse, Lange-Maia, Murray, Shah, and De Maio</u>	<u>2021</u>	<u>Structural racism, socio-economic marginalization, and infant mortality</u>	<u>Public Health</u>
<u>Benjamins, Silva, Saiyed, and De Maio</u>	<u>2021</u>	<u>Comparison of All-Cause Mortality Rates and Inequities Between Black and White Populations Across the 30 Most Populous US Cities</u>	<u>JAMA Network Open</u>
<u>Liao and De Maio</u>	<u>2021</u>	<u>Social Inequality, Political Factors, and COVID-19 Infections and Deaths Across US Counties</u>	<u>JAMA Network Open</u>
<u>Richardson, Malik, Darity, Mullen, Morse, Malik, Maybank, Bassett, Farmer, Worden, and Jones</u>	<u>2021</u>	<u>Reparations for American Descendants of Persons Enslaved in the U.S. and their Potential Impact on SARS-CoV-2 Transmission</u>	<u>Social Science and Medicine</u>
<u>Khazanchi, Crittenden, Heffron, Manchanda, Sivashanker, and Maybank</u>	<u>2021</u>	<u>Beyond Declarative Advocacy: Moving Organized Medicine And Policy Makers From Position Statements To Anti-Racist Praxis</u>	<u>Health Affairs Blog</u>
<u>Keelys, Baca, and Maybank</u>	<u>in press</u>	<u>Race, Racism, and the Policy of 21st Century Medicine</u>	<u>Yale Journal of Biology and Medicine</u>

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

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.

Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

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.

Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

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.

1 INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) REPEAL

2
3 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018
4 included provisions repealing the Independent Payment Advisory Board (IPAB). Currently, there
5 are not any legislative efforts in Congress to replace the IPAB.

6
7 CONCLUSION

8
9 Our AMA will remain engaged in efforts to improve the health care system through policies
10 outlined in Policy D-165. 938 and other directives of the House of Delegates.

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

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.

- 1 • D-215.989, "Studying Hospital Incentives for Admission, Testing and Procedures"
- 2 Our AMA will study the extent to which US hospitals interfere in physicians' independent
- 3 exercise of medical judgment, including but not limited to the use of incentives for admissions,
- 4 testing, and procedures.

5
6 This policy will be rescinded, having been studied in Council on Medical Service Report
7 5-A-15, "Hospital Incentives for Admission, Testing and Procedures."

- 8
9 • D-230.984, "Hospital Closures and Physician Credentialing"
- 10 1. Our AMA will develop model state legislation and regulations that would require hospitals
- 11 to: (a) implement a procedure for preserving medical staff credentialing files in the event of the
- 12 closure of the hospital; and (b) provide written notification to its state health agency and
- 13 medical staff before permanently closing its facility indicating whether arrangements have been
- 14 made for the timely transfer of credentialing files and the exact location of those files. 2. Our
- 15 AMA will: (a) continue to monitor the development and implementation of physician
- 16 credentialing repository databases that track hospital affiliations, including tracking hospital
- 17 closures, as well as how and where these closed hospitals are storing physician credentialing
- 18 information; and (b) explore the feasibility of developing a universal clearinghouse that
- 19 centralizes the verification of credentialing information, and report back to the House of
- 20 Delegates at the 2019 Interim Meeting.

21
22 The model legislation called for in paragraph 1 has been prepared and is available from the
23 Advocacy Resource Center, and your Board of Trustees presented Report 13-I-19 in fulfillment
24 of paragraph 2 of the policy. The policy will be rescinded.

- 25
26 • D-285.964, "Physician Payment by Medicare"
- 27 Our AMA will study the impact of hospital acquisition of physician practices on health care
- 28 costs, patient access to health care and physician practice.

29
30 This should be rescinded as the study was accomplished with Council on Medical Service
31 Report 2-A-15, "Physician Payment by Medicare."

- 32
33 • D-305.954, "For-Profit Medical Schools or Colleges"
- 34 Our AMA will study issues related to medical education programs offered at for-profit versus
- 35 not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden
- 36 of non-graduates versus graduates; (c) success of graduates in obtaining a residency position;
- 37 and (d) level of support for graduate medical education; and report back at the 2019 Annual
- 38 Meeting.

39
40 This policy will be rescinded as the Council on Medical Education issued Report 1-I-19 in
41 fulfillment of this directive.

- 42
43 • D-410.991, "Re-establishment of National Guideline Clearinghouse"
- 44 Our AMA will research possible and existing alternatives for the functions of the National
- 45 Guidelines Clearinghouse with a report back to the House of Delegates.

46
47 The Board of Trustees presented report 11-I-19 in fulfillment of this request. The policy will be
48 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,

1 subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county
2 participating in Medicare who are included in the plan's network.

3 4. Our AMA urges CMS to measure the stability of networks by calculating the percentage
4 change in the physicians in each specialty and subspecialty in an MA plan's network compared
5 to the previous year and over several years and post that information on Plan Finder.

6 5. Our AMA urges CMS to develop a marketing/communication plan to effectively
7 communicate with patients about network access and any changes to the network that may
8 directly or indirectly impact patients; including updating the Medicare Plan Finder website.

9 6. Our AMA urges CMS to develop process improvements for recurring input from in-network
10 physicians regarding network policies by creating a network adequacy task force that includes
11 multiple stakeholders including patients.

12 7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the
13 initial term or any subsequent renewal term of a physician's participation contract with a MA
14 plan.

15
16 Although the VerifyHCP product still exists, our AMA is no longer a partner, and AMA is no
17 longer offering the product. For this reason, paragraph 1(e) of the policy will be rescinded, with
18 any necessary renumbering accomplished editorially.

19
20 • D-383.978, "Restrictive Covenants of Large Health Care Systems"

21 ~~1. Our AMA, through its Organized Medical Staff Section, will educate medical students,~~
22 ~~physicians-in-training, and physicians entering into employment contracts with large health~~
23 ~~care system employers on the dangers of aggressive restrictive covenants, including but not~~
24 ~~limited to the impact on patient choice and access to care.~~

25 ~~2. Our AMA will study the impact that restrictive covenants have across all practice settings,~~
26 ~~including but not limited to the effect on patient access to health care, the patient-physician~~
27 ~~relationship, and physician autonomy, with report back at the 2019 Interim Meeting.~~

28
29 Board of Trustees Report 5-I-19 provided the study requested by paragraph 2 of the policy, so
30 that portion of the policy will be rescinded.

31
32 Changes effected by the Speakers' Report do not reset the sunset clock for those items rescinded in
33 part, and the changes are implemented upon filing of this report.

Fiscal Note: \$500 to edit PolicyFinder