

REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Russ Kridel, MD, Chair:

1. ANNUAL REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FILED

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

2. 2019 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOD ACTION: FILED

This informational financial report details all grants or donations received by the American 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	<u>44</u>
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	<u>15</u>
Nonprofit Contributors		<u>335</u>
Total Grants and Donations		\$ 1,185

3. AMA 2022 DUES

Reference committee hearing: see report of Reference Committee F.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**

See Policy G-635.130

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

4. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOD ACTION: FILED

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	<p>AHIP Consumer Experience and Digital Health Forum Sponsorship – Sponsorship with AMA name and logo.</p> <p>Managing Your Health and Wellness in the Era of COVID-19 – AMA name and logo use at World Health Day.</p> <p>Healthcare Administration Alliance’s (HAA) Conference – AMA’s Health Solutions participation with name and logo use.</p> <p>Consumer Privacy Framework for Health Data – Framework and webinar with AMA name and logo association with these organizations.</p>	<p>America’s Health Insurance Plans (AHIP) 3M (formerly Minnesota Mining and Manufacturing Company) Accenture Amwell (previously known as American Well)</p> <p>Livongo Health Inc. HLTH, LLC American Diabetes Association (ADA) American Heart Association (AHA)</p> <p>Healthcare Administration Alliance (HAA)</p> <p>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 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</p>	<p>11/6/2020</p> <p>4/7/2020</p> <p>9/15/2020</p> <p>8/25/2020</p>
EDUCATIONAL CONTENT OR GRANTS			
36512	<p>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.</p>	<p>LuCa (Lung Cancer) National Training Network University of Louisville School of Medicine Bristol-Myers Squibb (BMS) Foundation Cancer Care™ Initiative</p>	<p>1/27/2020</p>

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. 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.	Stanford University Stanford Center for Continuing Medical Education Pfizer, Inc. Morehouse School of Medicine ACE (Adverse Childhood Experiences) Consortium	9/24/2020 2/10/2020
COLLABORATIONS/AFFILIATIONS			
4753	Cardz for Kidz Sponsorship 2020 – Repeat sponsorship with AMA name and logo for program supporting hospitalized and traumatized children.	Cardz for Kidz!	12/18/2020
4929	Manatt Health – National policy roadmap focused on the nation’s drug overdose epidemic with AMA name and logo.	Manatt Health	12/15/2020
4958	Ad Council – National communications initiative with use of AMA name and logo, to educate the public and increase the use of the COVID-19 vaccines.	Ad Council (The Advertising Council, Inc.)	12/18/2020
5501	COVID Collaborative – Bipartisan coalition with AMA name and logo, focused on the effective response to COVID-19.	COVID Collaborative	12/23/2020
36397	HL7 Benefactor Membership – Renewal of membership with AMA name and logo.	Health Level Seven International (HL7)	2/4/2020

37393	ESSENCE Campaign to Promote Heart Health – Sponsorship with AMA name and logo in first quarter. Addition of Minority Health Institute (MHI) and WW International Inc. in fourth quarter.	ESSENCE Communications Inc. American Heart Association (AHA) National Medical Association (NMA) Association of Black Cardiologists, Inc., (ABC) Minority Health Institute (MHI) WW International Inc. (formerly Weight Watchers)	10/13/2020
37569	Physician Innovation Network (PIN) and Telehealth Implementation Playbook Collaborators – AMA Physician Innovation Network (PIN) and Telehealth Implementation Playbook collaboration agreements with limited AMA name and logo use.	MD++ R&T IMG Health In Her Hue The Rounds IEEE/EMBS (Engineering in Medicine and Biology Society) National Digital Inclusion Alliance (NDIA) Cambia Grove Xealth Medici OhMD, Inc. University of Louisville Texas Medical Association The Physicians Foundation Creekside Endocrine Associates	8/25/2020
38007	Research Project for High-Performing Physician-Owned Private Practices – Collaboration with AMA name and logo used in final report.	Mathematica	4/28/2020
38040	COVID-19 Healthcare Coalition – Organizational membership and participation in telehealth workgroup and study with AMA name and logo.	COVID-19 Healthcare Coalition	5/4/2020
38168	Hilton COVID Resident Relocation Support – Discounted extended Hilton hotel stay rates for residents featured in the COVID resource guides.	Hilton Worldwide Holdings Inc.	6/2/2020
38169	MAP (Measure, Act, Partner) Dashboards for Health Care Organization (HCO) – The AMA MAP BP™ Dashboard is an evidence-based quality improvement (QI) program providing sustained improvements in blood pressure (BP) control through monthly reports, tracking data and outcome metrics.	Tandem Health (South Carolina)	12/7/2020
38433	COVID-19 Writer’s Project – The COVID-19 Writers Project captures a viewpoint from inside a virus’s hotspot examining health outcomes that are impacted by socioeconomics, 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

5. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2020

Informational report; no reference committee hearing.

HOD ACTION: FILED

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

INTRODUCTION

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

Representing physicians with a unified voice

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

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

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

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

AMA launched a physician-focused webinar series with federal health officials that explored the COVID-19 vaccine development process and rollout. We also launched a comprehensive campaign across multiple platforms and channels to build confidence in the safety and efficacy of the new vaccines among physicians, other health care professionals and patients.

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

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

Removing obstacles that interfere with patient care

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

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

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

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

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

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

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

Leading the charge to confront public health crises

AMA's Center for Health Equity helped lead a national conversation about the pandemic's disproportionate impact on communities of color, the importance of accurate, nationwide data collection, and advanced policies that decrease inequities, supported equitable access to care and research, and improve culturally competent care.

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

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

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

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

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

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

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

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

Driving the future of medicine

AMA built upon strategic efforts to advance telehealth and improve physician well-being and practice sustainability during COVID-19 by developing dozens of free, online resources to help physicians better manage their mental health, keep their practices afloat, and foster widespread adoption of remote patient care through the Telehealth Initiative, the Telehealth Implementation Playbook and accompanying resource guide.

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

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

The AMA worked diligently to meet the needs of the medical education community during COVID-19. AMA developed the comprehensive AMA MedED COVID-19 resource guide as a centralized location to assist our

educators, residents and students in keeping up with new information and providing resources, links and a community discussion forum. AMA produced a series of webinars addressing COVID-19's impact on medical education and produced guidelines for trainees and others practicing in the pandemic.

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

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

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

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

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

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

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

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

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

Membership

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

EVP Compensation

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

For additional information about AMA activities and accomplishments, please see the "AMA 2020 Annual Report."

**6. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL:
MARCH 2020 THROUGH FEBRUARY 2021**

Informational report; no reference committee hearing.

HOD ACTION: FILED

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

TOBACCO USE AND COVID-19

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

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

TOBACCO USE AND HEALTH EQUITY

Study Looks at Menthol Cigarettes with a Social Justice Lens

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

Menthol has a cooling and anesthetic (or pain killing) effect. It can decrease the cough reflex and soothe the dry throat feeling that many smokers have. A study in the *American Journal of Public Health* found evidence that the tobacco industry was manipulating levels of menthol by promoting cigarettes with lower menthol content, which were popular

with adolescents and young adults, and providing cigarettes with higher menthol content to long-term smokers. Studies have shown that the tobacco industry has targeted Black youth and adult smokers for decades resulting in lower quit rates attributable to menthol. This connection between low quit rates in Black menthol smokers was also confirmed by the FDA's own findings.

AMA Joins in Lawsuit Against FDA

The American Medical Association joined the African American Tobacco Control Leadership Council and Action on Smoking and Health as co-plaintiffs in a lawsuit against the FDA. The complaint, initially filed in June 2020, requests that the court compel the FDA to fulfill its mandate to take action on FDA's own conclusions that it would benefit the public health to add menthol to the list of prohibited characterizing flavors and therefore ban it from sale.

In November 2020, the court denied the FDA's motion to dismiss the complaint, thus allowing the case to proceed to discovery. Following the decision, the National Medical Association was added as a plaintiff, and the FDA is currently working on a response to the citizen petition addressing their inaction on menthol to date.

OTHER EFFORTS TO ADDRESS TOBACCO CONTROL

AMA Supports Increased Funding for Tobacco Control Policy and Programs

The American Medical Association called on the U.S. Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to increase funding for the CDC Office on Smoking and Health by \$80 million. In a letter to then-subcommittee chair Senator Roy Blunt and then-ranking member Senator Patty Murray, health care organizations, medical associations and public health groups cited the rising increase in e-cigarette usage by teens and young adults and the continued toll that tobacco takes on the health of the nation.

The letter outlined that the added funds would allow CDC to effectively respond to the youth e-cigarette epidemic, including providing more resources to state and local health departments, expand its Tips from Former Smokers® (Tips®) media campaign and strengthen efforts to assist groups disproportionately harmed by tobacco products.

USPSTF Releases Updated Recommendations for Treating Tobacco Dependence in Adults including Pregnant Women.

To update its 2015 recommendation on smoking cessation, the USPSTF commissioned a review to evaluate the benefits and harms of primary care interventions on tobacco use cessation in adults, including pregnant persons. The updated recommendation reflects newer evidence and language in the field of tobacco cessation and includes a description of the 2019 E-cigarette or Vaping product use Associated Lung Injury, or EVALI, outbreak in the U.S. However, the recommended services that primary care clinicians should provide for tobacco cessation are the same as in 2015. The USPSTF continues to recommend that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. Pregnant women should be asked about tobacco use, advised to stop using tobacco, and provided behavioral interventions for cessation. There remains insufficient evidence to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons.

The USPSTF concludes that the evidence on the use of e-cigarettes for tobacco smoking cessation in adults, including pregnant persons, is insufficient, and the balance of benefits and harms cannot be determined. The USPSTF identified the lack of well-designed, randomized clinical trials on e-cigarettes that report smoking abstinence or adverse events as a critical gap in the evidence. The 2020 update was published in the January 19, 2021 issue of *JAMA*.

CDC's Tips® Campaign Increases Quit Rates

Findings from a CDC study published in *Preventing Chronic Disease* show that CDC's Tips® campaign led more than 1 million U.S. adults to quit smoking and an estimated 16.4 million U.S. adults to attempt to quit smoking during 2012–2018. To assess the campaign's impact on quit attempts and sustained quits, CDC analyzed data from a nationally representative longitudinal survey of U.S. adults who smoked cigarettes during 2012–2018.

The Tips® campaign was launched in 2012 and shows real people who are living with serious long-term health effects from cigarette smoking and secondhand smoke exposure. Through the campaign, people share compelling stories about their smoking-related diseases and disabilities and the toll these conditions have taken on them. The campaign also features nonsmokers who experienced life-threatening episodes because of exposure to secondhand smoke and family members affected by their loved one's smoking-related illness.

The 2020 U.S. Surgeon General's Report on Smoking Cessation cites studies showing that emotionally evocative, evidence-based campaigns like Tips® are effective in raising awareness about the dangers of smoking and helping people who smoke to quit.

TOBACCO USE SURVEILLANCE

CDC Morbidity and Mortality Weekly Reports (MMWR)

Cigarette smoking is responsible for more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. From March 2020 through February 2021, the CDC released eight MMWRs related to tobacco use. These reports provide useful data that researchers, health department, community organizations and others use to assess and develop ongoing evidence-based programs, policies, and interventions to eliminate and/or prevent the economic and social costs of tobacco use including electronic cigarettes.

Monitoring E-cigarette Usage Among Teens to Identify Strategic Control Policies

The September 18, 2020, and October 23, 2020, MMWR both highlighted e-cigarette use among youth, emphasizing the increased popularity of “pod mods,” which are products with a prefilled or refillable pod cartridge (pod) and a modifiable (mod) system. According to the report in the September 18 MMWR, e-cigarettes have been the most used tobacco product among U.S. youths since 2014 with 27.5% of high school students reporting current e-cigarette use in 2019. To assess trends in unit sales of e-cigarettes in the U.S. by product and flavor type, the CDC, the CDC Foundation, and Truth Initiative analyzed retail scanner data. By product type, the proportion of total sales that were prefilled cartridge products increased from 47.5% to 89.4% during September 2014–August 2019. The authors of the October 23 MMWR study noticed that the rise in pod mods coincided with the increased usage of e-cigarettes by youth. The popularity of the pod mods is due in part to the e-cigarette industry marketing the use of nicotine salts instead of freebase nicotine. Freebase nicotine is used in most other e-cigarette cartridges, or vaping, products and conventional tobacco products (e.g., cigarettes). According to the study, nicotine salts, which have a lower pH than freebase nicotine, allow particularly high levels of nicotine to be inhaled more easily and with less irritation to the throat than freebase nicotine. The most commonly sold pod mod brand is JUUL, which accounted for 75% of all U.S. e-cigarettes sales by the end of 2018. A majority (59.1%) of U.S. high school student e-cigarette users report JUUL is their usual brand.

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

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

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

7. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2011 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

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

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

RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.972	Generic vs Brand Medications	Our AMA will advocate to the US Food and Drug Administration against removal of generic medications from the market in favor of more expensive brand name products based solely on a lack of studies of the efficacy of the generic drug. Citation: Res. 220, I-11;	Retain – this policy remains relevant.
D-100.973	Stricter Oversight of Homeopathic Products by the Food and Drug Administration	Our AMA will urge the US Food and Drug Administration to review the existing regulatory framework for the approval and marketing of homeopathic drug products, including the Compliance Policy Guide, to determine if the current system is sufficient to reasonably ensure the safety and effectiveness of such products.	Rescind. FDA issued new draft guidance on Homeopathic products in 2019.

		Citation: (BOT action in response to referred for decision Res. 521, A-10; Reaffirmation A-11)	
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. Citation: (Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
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.	Rescind. This policy has been accomplished. Our AMA wrote a letter to CMS commenting on the new suspension of payment

		<p>Citation: (Resolution 220, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	<p>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:</p> <ol style="list-style-type: none"> (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. <p>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.</p> <p>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.</p>
<p>D-270.988</p>	<p>AMA Improve its Transparency, Accountability and Communication</p>	<p>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.</p> <p>Citation: (Res. 210, A-11)</p>	<p>Retain – this policy remains relevant.</p>
<p>D-275.964</p>	<p>Principles of Due Process for Medical License Complaints</p>	<ol style="list-style-type: none"> 1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician’s medical license, including strong protections for physicians’ rights. 2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant’s quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a 	<p>Retain – this policy remains relevant.</p>

		<p>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.</p> <p>Citation: (Res. 238, A-08; Appended: Res. 301, A-11)</p>	
D-315.981	National Master Patient Identifier	<p>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.</p> <p>Citation: (BOT Rep. 23, A-10)</p>	Retain – this policy remains relevant.
D-315.992	Police, Payer and Government Access to Patient Health Information	<p>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.</p> <p>Citation: (Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
D-330.922	Competitive Bidding for Purchase of Medical Equipment by Centers for Medicare and Medicaid Services	<p>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 consideration quality and patient convenience, in addition to cost.</p> <p>Citation: (Res. 814, I-08; Reaffirmed in lieu of Res. 201, I-11)</p>	<p>Rescind. This policy has been accomplished.</p> <p>Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the DMEPOS CBP was to be 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.</p>

			<p>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.</p> <p>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid</p>
D-330.969	Opposition to Mandatory Hospitalization Prior to Nursing Home Placement	<p>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 obsolete, wasteful of valuable resources and should be abolished.</p> <p>Citation: (Res. 139, A-02; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)</p>	<p>Rescind. Our AMA has completed this directive and has more recent and broad policy, including H-280.947, Three Day Stay Rule; H-280.950, Medicare’s Three-Day Hospital Stay Requirement.</p>
D-330.979	Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients	<p>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.</p> <p>Citation: (Res. 134, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	<p>Retain – this policy remains relevant.</p>
D-335.994	Medical Necessity Determinations under Medicare	<p>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.</p> <p>Citation: (Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11)</p>	<p>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.</p>
D-35.983	Addressing Safety and Regulation in Medical Spas	<p>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.</p> <p>Res. 209, I-11</p>	<p>Retain – this policy remains relevant.</p>
D-35.986	Encouraging the AMA to Ask the Robert Wood Johnson Foundation to	<p>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</p>	<p>Rescind. Our AMA continues to support physician-led teams; created the GEOMAPS (2008, 2014, 2018, 2020) and Health</p>

	Substantiate Report Findings Regarding Nurse Practitioners	independent practice states as an indicator that 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)	Workforce Mapper to show 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 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)	Retain – this policy remains relevant.
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	<p>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.</p> <p>Citation: (Res. 913, I-11)</p>	Retain – this policy remains relevant.
D-460.973	Comparative Effectiveness Research	<p>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.</p> <p>Citation: (Res. 221, A-11)</p>	Retain – this policy remains relevant.
D-478.979	Promoting Internet-Based Electronic Health Records and Personal Health Records	<p>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.</p> <p>Citation: (BOT Rep. 11, I-11)</p>	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	<p>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.</p> <p>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)</p>	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. 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)	Retain – this policy remains relevant.
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 episodes be reported to the Division	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.

		<p>of Private Sector AMA Advocacy unit for tracking purposes and to assist the involved/affected physician(s); and.</p> <p>(4) If abusive practices of the investigative agency are noted, the AMA will inform the Department of Justice of those tactics.</p> <p>Citation: (Res. 205, I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	
H-175.977	Disruptive Visits to Medical Offices by Government Investigators and Agents	<p>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.</p> <p>Citation: (Res. 211, A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-175.979	Medicare “Fraud and Abuse” Update	<p>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.</p> <p>Citation: (BOT Rep. 34, I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-175.981	Fraud and Abuse Within the Medicare System	<p>(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.</p> <p>(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.</p> <p>(3) The burden of proof for proving fraud and abuse should rest with the government at all times.</p> <p>(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.</p> <p>(5) Physicians must be accorded the same due process protections under the Medicare audit system or</p>	Retain – this policy remains relevant.

		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	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	Retain – this policy remains relevant.

	Skilled Nursing Facilities	deficits, who require less intensive rehabilitation at a Skilled-Nursing Facility, regardless of their specific medical diagnosis. Citation: (Res. 213, I-11)	
H-270.956	Evidence-Based Standard Requirement for Governmental Regulation	Our AMA supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate 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)	Retain – this policy remains relevant.
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, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	Retain – this policy remains relevant.
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	Retain – this policy remains relevant.

		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)	
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	<p>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.</p> <p>Citation: (Res. 805, I-93; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-04; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)</p>	Rescind. This policy is not relevant as our AMA has advocated more broadly to eliminate the three-day hospital stay requirement for SNFs.
H-330.964	Federal Budgetary Process Reform as It Affects Medicare	<p>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.</p> <p>Citation: (Res. 177, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-330.988	Free Choice by Patient and Physician Guaranteed	<p>Our AMA reaffirms the original intent of Title XVIII, Section 1802 of the Social Security Act, which guarantees free choice by patient and physician.</p> <p>Citation: (Res. 115, I-87; Reaffirmed: Res. 731, A-95; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-335.962	Recovery Audit Contractors Should Confirm Problem Has Not Already Been Resolved Before Undertaking an Audit	<p>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.</p> <p>Citation: (Res. 214, A-11)</p>	Retain – this policy remains relevant.
H-335.984	Medicare Regulatory Relief Legislation	<p>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:</p> <ol style="list-style-type: none"> (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; (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; 	Retain – this policy remains relevant.

		<p>(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</p> <p>(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.</p> <p>Citation: (Res. 213, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)</p>	
H-340.900	Quality Improvement Organization Program Status	<p>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.</p> <p>Citation: (CMS Rep. 1, A-97; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)</p>	Retain – this policy remains relevant.
H-340.917	Publication in Federal Register of Proposed Changes in QIO Review Process or Procedures	<p>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.</p> <p>Citation: (Sub. Res. 710, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	Retain – this policy remains relevant.
H-340.930	Peer Review <u>Quality Improvement</u> Organization Sanctions	<p>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.</p> <p>Citation: (Res. 185, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</p>	<p>Retain part of the policy.</p> <p>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.”</p>
H-340.931	Unannounced Enforcement of Regulation	<p>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.</p> <p>Citation: (Res. 199, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	Retain – this policy remains relevant.
H-340.932	Time Restrictions Placed on QIOs to Implement Changes in Review Procedures	<p>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.</p>	Retain – this policy remains relevant.

		Citation: (Res. 95, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	
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 to Effect Mass Retroactive Claims Adjustments	Our AMA will: (1) urge the Centers for Medicare & Medicaid Services to direct its carriers to effect 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)	Rescind. This policy has been accomplished. Our 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;	Retain part of the policy. Delete Clause (3) and renumber Clauses 4-7 accordingly. Our AMA has

		<p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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 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</p> <p>(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.</p> <p>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)</p>	<p>developed model legislation called for in Clause (3).</p>
<p>H-390.971</p>	<p>Hospitals Limited to Participating Physicians</p>	<p>Our AMA (1) advises its members that the decision of whether or not to be a “participating” physician in Medicare is a personal choice;</p> <p>(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;</p> <p>(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</p>	<p>Retain – this policy remains relevant.</p>

		<p>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.”</p> <p>“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 participate under this title if such institution, agency, or person undertakes to provide him such services;”</p> <p>(4) supports rescinding the “incentive” in OBRA 1986 regarding hospital referral of Medicare patients to participating physicians;</p> <p>(5) supports amendment of the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and</p> <p>(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.</p> <p>Citation: (Res. 31, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	
H-420.978	Access to Prenatal Care	<p>(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.</p> <p>Citation: (Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11)</p>	Retain – this policy remains relevant.
H-425.973	CMS Should Provide Date Eligibility Information to Beneficiaries	<p>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.</p> <p>Citation: (Res. 213, A-11)</p>	Retain – this policy remains relevant.
H-425.978	Stroke Prevention and Care Legislation	<p>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.</p> <p>Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	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. Citation: (Res. 223, I-91; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
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.	Retain – this policy remains relevant.

		Citation: (BOT Rep. I, I-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	
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 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)	Retain – this policy remains relevant.
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.

8. PLAN FOR CONTINUED PROGRESS TOWARD HEALTH EQUITY (CENTER FOR HEALTH EQUITY ANNUAL REPORT)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOD ACTION: FILED

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 Keeys, Director of Health Equity Policy and Advocacy, and Joaquin Baca, Senior Health Equity Policy Analyst, developed the Supplemental Health Equity in Advocacy and Policy Immersive Development, Training, & Engagement Curriculum, referred hereafter as "the Curriculum." The purpose of the immersive development, training, and engagement program was to imbue advocacy and policy day-to-day tasks with equity practices. The Curriculum consisted of three, separate full-day or half-day immersive workshops exclusively for Advocacy staff of both the Chicago and Washington, DC offices.

At the end of the workshop series, participants were able to: define health equity in a way that differentiates it from other terms such as health disparities, health inequalities, and health inequity in discussions, written work, and presentations; explain how adopting an equity mindset is essential to all aspects of advocacy work; and apply an equity lens to policy analysis, development, and promotion with proficiency in a normal work environment. Table 1 in the Appendix further outlines the descriptions of each Module.

(2) Equity in Advocacy: External Impact
AMA Congressional Activities

In addition to the internal work that CHE staff executed with the Advocacy BU, Center staff also supported pivotal Congressional activities. In June 2020, AMA Immediate Past President Dr. Patrice A. Harris delivered [Congressional testimony](#) to the House Budget Committee Hearing, *Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change*. Her words garnered gratitude from Kentucky Representative John Yarmuth, who is also the Congressional Representative of the slain Breonna Taylor. As we near the year anniversary of her murder by police, we may also reflect on Dr. Harris's testimony, which the CHE was instrumental in crafting and reviewing alongside Advocacy and Enterprise Communications.

In summer 2020, the House Committee on Ways and Means Chairman Richard Neal (D-MA) released to AMA and several other societies/organizations a letter spurred by a *New England Journal of Medicine* (NEJM) article on race and clinical algorithms. The letter called on professional medical societies to push racial health agenda forward and requested information on the misuse of race within clinical care. The Advocacy BU led to response effort, with substantial CHE support under the auspices of one of our driving strategic approaches, embedding equity across health innovations.

As outlined in last year's CHE report, the CHE had written Congressional bill language calling for the collection of equitable data regarding COVID-19 testing, namely race/ethnicity and preferred spoken/written language. Parts of [H.R. 6865, the Equitable Data Collection and Disclosure Act](#) were eventually included into the CARES Act, the first COVID-19 relief package. In late Quarter 3, the AMA submitted a ["thank you" and an official endorsement letter](#) to the bill's primary sponsor, Rep. Robin Kelly (D-IL). Equitable collection of REI data continues to be a major problem, but now with respect to COVID-19 vaccination distribution. The CHE, alongside Advocacy, continues to ring the alarm about REI data collection, but now with respect to COVID-19 vaccine distribution. (In February 2021, the AMA, American Nurses Association, and the American Pharmacists Association released a letter calling for a bolstering of REI data on COVID-19 vaccine distribution.)

- (3) The CHE has also been working with the Office of General Counsel (OGC) to ensure that AMA works to advance equity within judicial settings. For example, the AMA, alongside African American Tobacco Control Leadership Council (AATCLC), Action on Smoking and Health (ASH), and the National Medical Association (NMA), [joined a lawsuit against the FDA, mandating action on banning menthol cigarettes](#). The suit was filed on June 17, 2020 in the United States District Court in Oakland, California and asserts that contrary to the duties imposed by the Family Smoking Prevention and Tobacco Control Act ("Tobacco Control Act"), the FDA failed to act on menthol cigarettes, and requires the FDA to ban menthol cigarettes or, in the alternative, to give a public, cogent explanation of their reasoning. The title of the case is *African American Tobacco Control Leadership Council, Action on Smoking and Health, and American Medical Association v. U.S. Department of Health and Human Services, et al.* Given that addiction to menthol cigarettes has been cited as highest among youth, and associated with higher rates of smoking frequency and death amongst African Americans, the health equity implications of menthol cigarettes are heinous. The CHE and OGC also collaborate in judicial advocacy on other equity issues such as sugar-sweetened beverages, the opioid crisis, LGBTQ protections, reproductive justice, immigration-related issues, and evictions and housing, among others.
- (4) Conducted in collaboration with the Environmental Intelligence, Survey and Market Research (EISAMR) BU, the Minoritized & Marginalized Physician Survey captured the barriers that historically marginalized and minoritized physicians face/have faced in delivering care during the pandemic of COVID-19. CHE prioritized sharing these initial insights with internal BUs and workgroups to inform their efforts to support the unique needs of historically marginalized and minoritized physicians. These insights have been shared with the Telehealth Working Group, the Internal LGBTQ+ Working Group and the LGBTQ Advisory Committee. Current efforts include creating a series of external reports illuminating the experiences of racially minoritized physicians and of LGBTQ+ physicians by end of second quarter of 2021. Efforts to highlight the experiences of physicians with disabilities will begin the second quarter of 2021.
- (5) In May 2020, the Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation asked the CHE to review and provide feedback on newly revised 10 Essential Public Health Services (EPHS) framework. The original 10 Essential Public Health Services (EPHS) framework was developed in 1994 by a federal working group. It serves as the description of the activities that public health systems should undertake in

all communities. Health departments and community partners around the nation organize their work around the EPHS framework; schools and programs of public health teach it; and the framework informs descriptions and definitions of practice. The framework is also used as the basis of the Public Health Accreditation Board Domains. The framework has provided a roadmap of goals for carrying out the mission of public health in communities around the nation. However, the public health landscape has shifted dramatically over the past 25 years, and many public health leaders agreed it was time to revisit how the framework can better reflect current and future practice and how it can be used to create communities where people can achieve their best possible health. The CHE contributed significantly to the new framework and submitted its suggestions in August 2020, which may be found [here](#).

- (6) The Center for Health Equity, Human Resources, Enterprise Communications, and Environmental Intelligence business units worked together to launch the inaugural All Employee Engagement and Equity Assessment. The objective of the assessment was to understand and enhance employee engagement and satisfaction, ensure an equitable and inclusive workplace for all employees, and advance health equity through the organization's external efforts. The core AMA assessment team worked with outside consultants to design and field a survey that launched in July 2020 and garnered a response rate of 92.35% (1,099 of 1,190 employees). The survey was followed by a series of focus groups to further amplify the voices of demographic groups with the lowest engagement rates based on survey results. A detailed report of the AMA All Employee Engagement and Equity Survey results was published internally and used to engage in dialogue with employees across the organization, including enterprise-wide, within BUs, and with Employee Resource Groups. A roadmap for enterprise-wide and BU action planning was shared.
- (7) With the addition of Chelsea Hanson as Director of Health Equity & Innovation to the Center in summer 2020, work began in earnest on internal and external stakeholder discussions and landscape analyses to inform the Center's "Ensure equity in innovation" approach.

4th Quarter, 2020

- (1) Historic Passage of Three Anti-Racism HOD Policies

The Center commends the outstanding work of the AMA Medical Student Section (MSS), the Minority Affairs Section (MAS), and the Women Physicians Section for their work in introducing three legacy antiracism policies, which were adopted during the November 2020 Special Meeting of the AMA House of Delegates. The mark of these three outlined policies—H-65.952, "Racism as a Public Health Threat, AMA Health Policy"; H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, AMA Health Policy"; and D-350.98, Racial Essentialism in Medicine"—is indelible. Following the passage of these policies, the Chief Health Equity Officer [published an article in *Essence* magazine](#) to emphasize its significance.

The passage of these policies will facilitate the AMA's stronger support of congressional, federal, and state level antiracist policies. The CHE anticipates working closely with Advocacy to leverage these policies toward the effect.

During this historic HOD session, Dr. Maybank and other CHE staff were invited to present to several sections on health equity topics. This included presentations to the Medical Student Section, the International Medical Graduates Section, and the Senior Physicians Section.

- (2) Health Equity Learning Series and Health Equity Spotlight Modules

Under the CHE leadership of Alice Jones, Program Manager, Health Equity Performance and Operations, the AMA is intentionally expanding its focus on inequities associated with disabilities, which was not a strong focus of the CHE until recently. The Access Health Employee Resource Group (ERG) Series were carried out between November and December 2020. Disability 101 focused on basic concepts related to identifying as disabled, including stigma, etiquette, and explanation of Social vs Medical Models of Disability. Disabilities at Work highlighted how to be inclusive, and emphasized hiring and retaining, and reasonable accommodations. The Disability Now and Then workshop gave an overview of social context for people with disabilities (ADA, contemporary issues with accessibility despite the ADA). The work of the ERG draws attention to the spaces our AMA must still address with respect disability equity across the AMA workforce, as well as in medicine, in

general. In the future, the CHE looks forward to reviewing, evaluating, and providing feedback on AMA's handling of reasonable accommodations (including ones for electronic accessibility standards) for both new hires and for existing staff. Table 2 in the Appendix lists AMA policies relevant to disabilities and reasonable accommodations.

Also, under co-leadership of CHE and Health Solutions, creation of some educational opportunities around gender identity and non-binary pronouns. The group developed a modules to support staff's developing confidence and ease with sexual orientation and gender identity.

- (3) Two critical efforts in support of the "Ensure Equity in Innovation" approach were completed. The first, in October 2020 was the formation and launch of an AMA External Equity & Innovation Advisory Group comprised of 11 experts at the intersection of health equity and innovation, a diverse group of leading physicians, entrepreneurs, investors, and advocates for the health and wellbeing of historically marginalized and minoritized communities. The group held its first quarterly meeting with CHE leadership and began to formulate its collective vision and values. The second effort was the completion and publication of an analysis of twenty-five interviews of internal AMA, Health2047, and Health2047 Capital Partners innovation stakeholders conducted by Center for Health Equity consultant, Braven Solutions, to understand opportunities to support the embedding of equity into existing innovation efforts across our ecosystem.
- (4) Toward the end of 2020, CHE, under the planning of Denard Cummings, the CHE Director of Equitable Health Systems Integrations, collaborated with HealthBegins to develop the AMA Upstream Strategy Primer to support the ongoing work of the AMA Social Determinants of Health Workgroup. The CHE is executing the Upstream Strategy with PS2, IHMI, and EISAMR. The role of the Upstream Strategy is to leverage the existing AMA policies on social determinants of health and public health to move AMA's interventions closer to the foundations of avoidable inequities in health.
- (5) Our AMA is making strides with respect to written language equity. While there is much room to grow, the CHE's own Dr. Diana Derige and Dr. Diana Lemos led the work with Enterprise Communications on our AMA's Hispanic Heritage Month campaign, one of the first AMA entirely bilingual campaigns. The final product was a multimedia news release and resource for media outlets to consume and report on our AMA content produced in [English](#) and [Spanish](#). Drs. Derige and Lemos were also deeply instrumental in producing The AMA Latinx Health Inequities Report, which reports on Latinx ethnic data and uncovers the true magnitude of COVID-19 on the Latinx community.
- (8) Another notable accomplishment has been the creation of the AMA internal Language Access Plan, also led by CHE staff. The Language Access Plan includes best practices and guidance to support an inclusive AMA policy to ensure access under Language Access Obligations Under Executive Order 13166 and meaningful access for limited English proficient persons under the national origin nondiscrimination provisions of Title VI of the 1964 Civil Rights Act. Our [AMA Health Equity Initiatives Webpage](#) went live in September 2020. It features content from healthcare, governmental and community organizations across the country that are working to provide resources to minoritized and marginalized populations, dismantling racist systems and improving patient trust in the health care system. The CHE partnered with these organizations to collect their insights to help our AMA better understand the history of the project or initiatives, the overall goals of the projects and initiatives, the expected results and early wins, as well as the key partners involved in the effort.
- (9) In November 2020, the CHE hired Gina Hess as Operations Assistant. Amongst other pertinent organizational capacity work, Ms. Hess tracks the CHE team's information for presentations, keynotes, and panels, and co-coordinates the bi-weekly Prioritizing Equity Series with Aziza Taylor, CHE's Communications and Marketing Manager, and with the Digital Strategy and Operations team of Enterprise Communications.

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

workflow for processing the Prioritizing Equity honoraria for guest speakers, and helped to revamp the CHE SharePoint site.

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

- (10) Starting in 2020 and continuing into 2021, CHE has contributed expertise to the google.org-backed Health Equity Task Force convened by Dr. Daniel Dawes, Satcher Health Institute. The Task Force is guiding the creating of a public-facing health equity tracker, with the goal of providing accessible and impactful data to a wide range of users. CHE staff represented two different subcommittees within the Task Force—the Data Consortium and the Population-Based Strategies Work Group.
- (11) As the year came to a close, the CHE continued to expand the equity presence and visibility of the AMA. Since 2020, CHE staff have delivered keynotes and moderated panel conversations close to 160 in number. Table 3 in the Appendix outlines these events.

1st Quarter, 2021

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

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

Table 4 of the Appendix lists the books, research papers, and other notable publications produced by CHE staff, over the last year. These include a book, *Unequal Cities: Structural Racism and the Death Gap in America’s 30 Largest Cities*, published by the Johns Hopkins University Press as part of its “Health Equity in America” series.

CHE members have also co-authored articles in leading scholarly journals, including the *Lancet*, *Health Affairs*, *JAMA Network Open*, the *American Journal of Preventive Medicine*, and *Public Health*.

In progress are an edited book on structural competency and the COVID-19 pandemic (co-edited by Aletha Maybank, Fernando De Maio, Jonathan Metzl and Uché Blackstock) and an edited theme issue for the *AMA Journal of Ethics* (Fernando De Maio, Diana Derige, and Diana Lemos) bringing together nine cases/papers from leading scholars of Latinx health equity.

- (4) Between January and March 2021, several new members joined the team. Karthik Sivashanker, MD, MPH, CPPS, joined as Vice President of Equitable Health Systems and Innovation. He also serves as the Medical Director of Quality Safety and Equity of Brigham Health. Joni Wheat joined the team as our Program Administrator. Dr. Zain Al Abdeen Qusair and Dr. Iqra Hashwani joined as interns from DePaul University's Master of Public Health program, working under the supervision of Fernando De Maio, PhD, Director of Research and Data Use. The bolstering of the CHE team strengthens the AMA's national position as equity brokers in medicine and public health. CHE secured a memorandum of understanding (MOU) with Northwestern University's Public Health program to increase intern support for the team and to expand opportunities for MPH and MD/MPH students to learn and contribute to the work of the Center.
- (5) The AMA External Equity & Innovation Advisory Group reconvened with the Center for Health Equity for its second quarterly meeting in February 2021. The group engaged in interactive breakout discussions that included AMA and Health2047 innovation stakeholder participants.
- (6) CHE is working in partnership with Health Solutions and Medical Education on strengthening race and ethnicity data collection in the AMA Masterfile, and with the explicit purpose of building a data foundation toward a more equitable health system. Under the leadership of Fernando De Maio, CHE worked with Kenyetta Jackson of Health Solutions to execute the first ever Physician Data Collaboration Summit in February 2021, a meeting with internal stakeholders across the AMA business units, and with external steering committee, including representatives from the ACGME and AAMC. The group continues to meet in 2021, with the goal of establishing common data standards and definitions and a collaborative research agenda examining diversity of the physician workforce.

The AMA, led by CHE, submitted a proposal for the global challenge address Racial Equity 2030. The RFP called for bold solutions to drive an equitable future for children, their families and communities. Our proposal aims to address medicine's historical production of scientific, cultural, structural, and institutional racism and dismantle its roots; centering restorative and "just" healthcare and meaningfully engages all voices to fundamentally change medicine and the health of our nation.

- (7) Working with the American College of Preventive Medicine, CHE responded to an open request for proposals to support solo or small group practices of racial and ethnic minority physicians to accelerate the capacity of implementing COVID-19 prevention, testing, and vaccination strategies within racial or ethnic minority communities. Under the Centers for Disease Control and Prevention (CDC), this is the OT18-1802 Cooperative Agreement, "Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health Improving Minority Physicians' Capacity to Address COVID-19 Disparities". The intent of this work is to increase physicians' ability to capture and collect case studies and to engage patients in impactful conversations about COVID-19 and to make resources available to their patients. For the first time in its 174-year history, our AMA is producing a strategic roadmap that outlines a framework to address inequities in health care. Given the enormity of work that achieving health equity entails, it is critical for the American Medical Association to outline, define and chart a path to success to allow us to not only monitor our progress but to also facilitate transparency, accountability, and continuous quality improvement in the process. The plan is aligned with the Center for Health Equity's five strategic approaches: embed equity; build alliances and share power; ensure equity in innovation; push upstream; and create pathways for truth, racial healing, reconciliation, and transformation.

2nd Quarter, 2021 and 3rd Quarter 2021 Projections

- (1) The Board's first report to the House of Delegates on the CHE gave the early outline for what will henceforth be referred to as the Centering Equity in Emergency Preparedness and Response Recovery Initiative for Healthcare (the CEEPRR). The CEEPRR is created in partnership between our AMA and confirmed partners, including the

Planned Parenthood Federation of America (PPFA), American College of Preventive Medicine (ACPM), American Public Health Association (APHA), National Medical Association (NMA), National Hispanic Medical Association (NHMA), GLMA, American Association of Public Health Physicians, America’s Essential Hospitals, American Academy of Family Physicians, and the National Birth Equity Collaborative. The CEEPRR will serve as a resource for healthcare professionals and for healthcare organizations to embed and implement equity strategies and tactics to prepare and respond to emergencies. There is a dearth of guidance and community in healthcare in this domain. The initial product will include a guide/playbook with guiding principles, critical shared terminology, and illustrative case studies. There will be opportunities to extend this asset via other amplifying opportunities such as the Ed Hub. The CHE is using a collaborative approach to inform product development, innovation, and amplification. This initiative will be the first of its kind and a unique opportunity to promote and establish more equitable policies, practices and service behaviors across healthcare. The anticipated release date is for May 2021.

The “Ensure equity in innovation” strategy will continue to be developed with the guidance of the AMA External Equity & Innovation Advisory Group and through market research and stakeholder engagement that centers the voices of patients, innovators, and investors from historically marginalized and minoritized communities. This research and stakeholder engagement will inform collaborative strategic initiatives and policies, internal training and tools, and external industry-facing content and resources to be launched in 2021 and beyond.

APPENDIX

TABLE 1: Health Equity in Advocacy and Policy Immersive Development, Training, & Engagement Curriculum Modular Description

Training at a Glance	
Module 1: Why an Equity Mindset is Essential to Work in Policy and Advocacy	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • 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,”	<p>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.</p> <p>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</p>

		<p>maximum and will hasten the processes of their social and professional integration or reintegration.</p> <p>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.</p>
H-65.965	“Support of Human Rights and Freedom,”	<p>Our AMA:</p> <p>(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.</p>
D-180.991	“Work Plan for Maintaining Privacy of Physician Medical Information”	The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities.
H-90.987	“Equal Access for Physically Challenged Physicians,”	Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.
H-200.951	“Strategies for Enhancing Diversity in the Physician Workforce,”	Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce,” and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
9.5.4	Civil Rights & Medical Professionals	Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.
	AMA Principles of Medical Ethics: IV: Balance with patient safety	

TABLE 3: CHE Keynotes, Panels, and Other Speaking Engagements

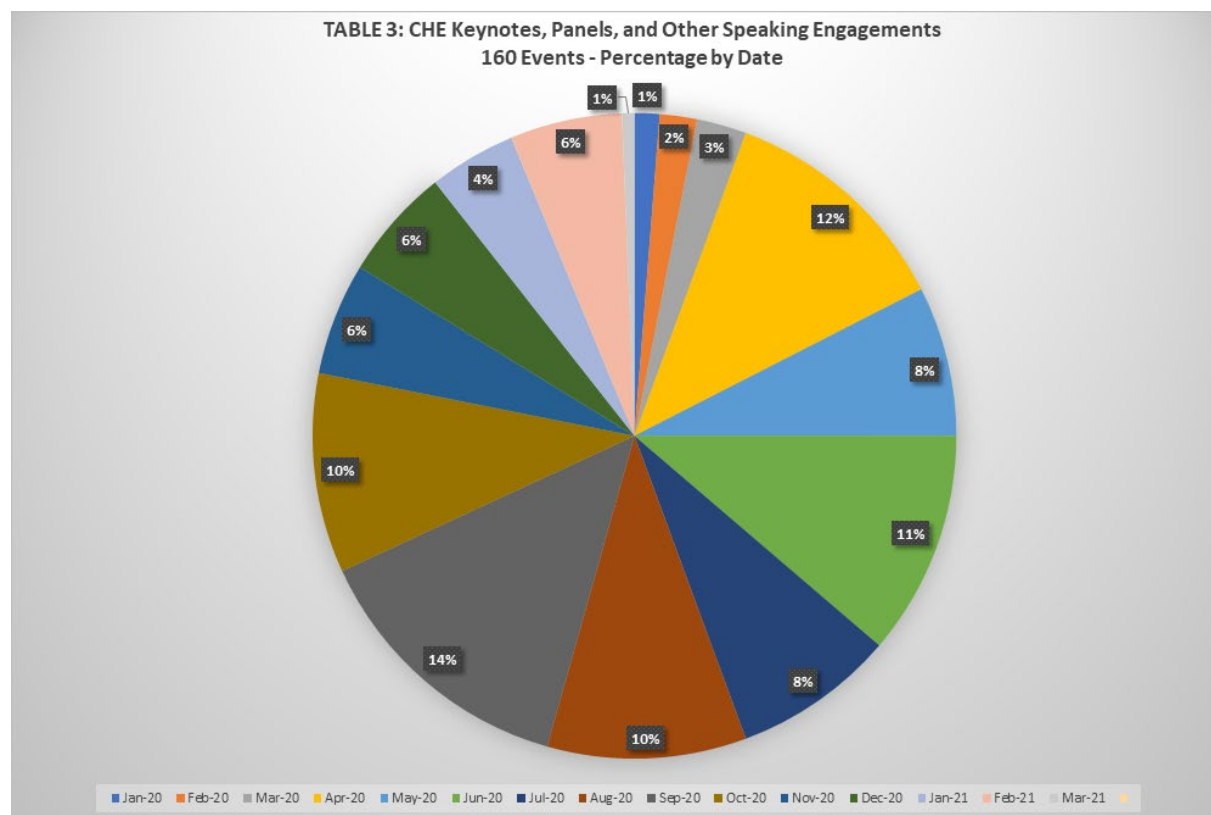


TABLE 4: CHE Peer-Reviewed Publications

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

Note: CHE authors in bold

TABLE 5: Prioritizing Equity Series

Table 5: Prioritizing Equity Series	DATE
COVID-19 & Minoritized Physicians	3/11/2021
COVID-19 & Trauma Informed Approaches	2/25/2021
COVID-19 & Disability	2/11/2021
COVID-19 Vaccine & Equitable Distribution	1/28/2021
After Show: Trustworthiness and Vaccines	12/10/2021
Trustworthiness and Vaccines	12/10/2020
Research and Data for Health Equity	11/19/2020
2020 Election - Moving Forward	11/12/2020
Examining Race-Based Medicine	10/29/2020
Structural Racism and the Latinx Community	10/15/2020
Chicago's Response to COVID-19	10/1/2020
Voting During the COVID-19 Pandemic	9/17/2020
Lessons NYC has learned from COVID-19	9/3/2020
Political Determinants of Health	8/20/2020
Mental Health & COVID-19	8/6/2020
Asian American & Pacific Islander Voices	7/16/2020
Moving Upstream	7/7/2020
LGBTQ Voices	6/18/2020
Root Cause & Considerations for Healthcare Professionals	6/11/2020
Police Brutality & COVID-19	6/4/2020
The Root Cause	5/28/2020
COVID-19 & Native in the Field	5/21/2020
Latinx Voices in the Field	5/14/2020
COVID-19 & the Experiences of Medical Students	5/7/2020
Strengthening the Public Health Infrastructure to Battle Crises	4/23/2020
The Experience of Physicians of Color and COVID-19	4/2/2020

**9. PRESERVATION OF THE PATIENT-PHYSICIAN RELATIONSHIP
(RESOLUTION 703-A-19)**

Reference committee hearing: see report of Reference Committee G.

**HOD ACTION: RECOMMENDATIONS ADOPTED
RESOLUTION 703-A-19 NOT ADOPTED
REMAINDER OF REPORT FILED**

INTRODUCTION

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

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

BACKGROUND

The relationship between a patient and their physician is sacred. It requires trust, honesty, and communication. As the healthcare industry has changed in recent decades, so have external factors and internal dynamics that influence the patient-physician relationship. Both the patient’s and physician’s roles and experiences have evolved, as well as their perceptions and expectations of the communication and relationship with each other. Many factors contribute to the patient-physician relationship, including electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by

technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.

AMA POLICY

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

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

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

Recognizing that government has a large influence on the practice of medicine, the AMA continuously works to reduce the burden of government and third-party regulation on medical practice and its intrusion into the patient-physician relationship and doctor-patient time (Policy H-180.973, "The "Hassle Factor"). The AMA will continue these efforts, with additional focus on the prescription of medication (Policy H-100.971, "Preserving the Doctor-Patient Relationship"). Furthermore, the AMA endorses principles concerning the roles of federal and state governments in the patient-physician relationship:

- A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially

dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.

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

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

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

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

DISCUSSION

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

- Shared decision-making
- Online health/medical information
- Health literacy
- Trust
- Implicit bias
- Adequate time
- Physical clinic setting
- Communication
- External influences

Barriers to communication and an effective patient-physician relationship can be encountered at many points during the interactions between a patient and physician. Barriers can also manifest from inherent attitudes or outward behaviors, of the patient and/or physician. Finally, barriers that affect the quality of patient-physician interactions are often external environmental elements, such as technology or the availability of support staff.

Shared decision making

Sharing in the decision-making process can help patients feel their voice is heard and their physician cares what they think and feel about their condition and the options for treatment. Patients value having the opportunity to explain their illnesses, receive information, and be involved in their treatment plans.^{1, 2} This requires deliberate attention and thoughtful consideration on the part of the physician. Barriers can arise if patients are simply presented with results and standard check-box choices without discussion. This approach can leave them feeling less than cared for. In addition, the use of decision support tools, while mostly beneficial when used appropriately, can get in the way of quality conversation in which patients and physicians decide together the best course of action.³ A study of physicians with a "participatory decision-making style" showed this approach resulted in better health outcomes and more satisfied physicians. This research also found that physicians with a more participatory decision-making style were 30 percent less likely to have patients leave their care.

Online health/medical information

An important part of the patient-physician relationship is ensuring patients have the right amount of appropriate and accurate information about their health and medical conditions. In today's internet-driven and information-loaded environment, physicians are often not the initial source of information about medical conditions or potential treatments. Patients are increasingly arriving at a clinic visit after reading information on medical information websites, sometimes even with a specific diagnosis in mind. This can be either problematic or beneficial for the patient-physician relationship, depending on whether and how the patient discusses what they have learned with their

physician.⁴ For example, 80 percent of physicians report that access to online information has increased the likelihood that patients question their diagnosis or treatment plans.⁵ Confirming this observation, a study of patient perspectives revealed that when patients valued information found on the internet above their physician's, that information led them to ignore their physician's expertise.^{4, 6} On the other hand, if patients openly discuss their findings with their physician and the physician is receptive to that discussion, this open communication can benefit the patient-physician relationship.⁴ Some patients believe that information seeking and discussion about that information with their physician enhances their relationship with their physician and supports their physician's advice.⁴ While it can sometimes create barriers, online health and medical information accessed and used appropriately can benefit patients and physicians, and enhance their communication and overall relationship.

Health literacy

Although many patients are increasingly discussing self-searched health information with their physicians, and physicians are more often sharing information with patients throughout decision-making, it does not mean that patients always understand or can accurately interpret the information they are learning. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.⁷ Low health literacy, primarily affecting older adults, minority populations, medically underserved people, and those with low socioeconomic status, can create barriers between the patient and their physician. Reasons for low health literacy include language limitations, limited education, use of medical vernacular by health care staff and clinicians, hearing impairment and cultural differences. These patients may have trouble communicating their complaints and health history to the physician or they may not understand the risks their behaviors pose on their health. They may not understand insurance and how to use their benefits, and they may have difficulty understanding medications and their effects.⁷ For some, the increase in access to information has improved understanding and knowledge of their health.⁸ Although there is more online health care content than ever, and mobile health applications give patients more access and control over their health information, medical information websites or mobile applications are not always available to everyone. Patients with low health literacy are less likely to use computers and web applications (e.g., email, search engines, and online patient portals), limiting the benefits these sources of information have for certain populations.⁹

Trust

Trust between patients and their physicians is crucial. Patients may have a general distrust of the medical profession due to a bad experience. They may need time to build trust with their physician, or they may not feel their physician has their best interest in mind. Physicians, on the other hand, may lack trust in their patient if the patient ignores treatment or medication plans, cancels or doesn't show up for appointments, or neglects to provide complete information about health history. Shared decision making and open, non-judgmental dialogue about health and medical information as previously discussed, can help foster trust between patients and physicians. In addition, physicians and patients alike may harbor distrust as a result of implicit bias against the other party.¹⁰

Implicit bias

Implicit bias, on the part of the physician or the patient, negatively affects the patient-physician relationship for many reasons. For patients, biases about providers can have implications for access to care. For example, 29 percent of patients in one survey said they would avoid a certain provider based on personal characteristics such as race, gender, or age.¹¹ Getting in the way of a caring and respectful relationship are biased remarks made toward clinicians based on characteristics like weight, gender, or ethnicity. Fifty-nine percent of clinicians have experienced bias due to their physical appearances and 70 percent of Black and Asian clinicians report hearing biased remarks.¹¹ Some biases can exist based on accents or attire such as certain types of headwear. Physicians can also bring biases to their practice. Implicit attitudes about personal characteristics such as weight or race can affect the way they interact with and treat patients.^{12, 13} Predisposed notions about patients based on these outward-facing characteristics can unfairly influence a physician's judgment about the individual's condition or the best course of treatment. This inhibits the quality of patient care and damages the patient's trust that the physician has their best interest in mind.

Adequate time

Sufficient time to focus on the patient during a clinic visit is important for both the patient and physician to develop and maintain a healthy and productive relationship. The patient needs time to ask questions and discuss their

symptoms, concerns, and history. If they feel rushed by the physician, even if the physician does not intend to send that signal, the patient may feel unimportant and not cared for. The effective use of the patient visit by the physician gives the patient the sense they have been heard and they can comfortably express their concerns and feelings.¹⁴ Feeling that they are the focus of the physician's attention and that they have been heard is more important to patients than the actual amount of time spent together.¹

Likewise, physicians want to have sufficient time with their patients to gather important information, look their patients in the eyes, and really listen to their concerns. Research has shown that one of the primary sources of physician satisfaction is patient relationships and one of the primary sources of dissatisfaction is "time pressure."¹⁵ Productivity requirements and pressure to keep appointments to short durations can put pressure on physicians to limit their visit lengths to only a few minutes. In addition, documentation requirements force the physician to spend an inordinate amount of time focused on their electronic health record (EHR) rather than their patient.¹⁶

Recent data show that 33 percent of physicians in the U.S. spend 17 to 24 minutes with each patient. Twenty-nine percent spend 13 to 16 minutes, and just 11 percent spend 25 or more minutes with each patient.¹⁷ Research shows that longer visits allow for more attention to several aspects of care, including increased patient participation, patient education, preventive care, and performance of immunizations. In addition, patients are more likely to feel they had inadequate time with their physician in visits scheduled to last five minutes compared with visits scheduled to last 10 and 15 minutes.^{18, 19} In the U.S., visit rates above three to four per hour are associated with suboptimal visit content. Because patient satisfaction is increased by increased patient participation and activities to educate the patient, it is suggested that more than three to four visits per hour would be associated with decreased patient satisfaction.²⁰

Despite the efforts to identify the "optimal" amount of time for patient visits, it remains an elusive goal, owing much to variability in patient visit lengths across specialties and countries.²⁰ In addition, because every patient is different and every patient-physician encounter is unique, it is difficult and not preferable, to designate a universal minimum time for patient visits. To improve the patient-physician relationship, the focus of physicians' energy should be on quality interactions and value-added tasks, rather than monitoring how many minutes they spend with the patient for billing purposes.

Physical clinic settings

The way in which a physician's office or patient room is designed and organized can create barriers to optimal communication with patients. Patient rooms in which a desk is placed so that the physician cannot look at the patient do not allow for valuable eye contact and hands-on interaction. A similar effect may occur if the physician places the computer screen between 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:

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

Documentation requirements

Increasing documentation requirements from Medicare and commercial payers have also added to physicians' administrative workload. A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive.³⁷ Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting, and increased demand for data. Much of the U.S. medical coding system is time-based,^{38, 39} which has led to overemphasis on the amount of time spent with each patient and excessive focus on "checking the boxes" to ensure documentation requirements are met. The Centers for Medicare and Medicaid Services (CMS) recently enacted changes to the documentation requirements for evaluation and management (E/M) services developed by the AMA's CPT Editorial Panel. These changes will allow physicians to

bill based on case complexity with less emphasis on the number of minutes spent. Physicians will only be required to enter medically necessary information, enabling them to spend more time connecting with their patient to collect high-value, relevant information instead of redundant information. Further discussion on the Medicare E/M coding changes and their anticipated benefits to the patient-physician relationship is presented in another section of this report.

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

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

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

Prior authorization

It has been well-documented, by the AMA and others, that prior authorizations required by payers are another source of dissatisfaction and burden for physicians.^{44, 45} In addition to being a source of burden, a 2019 AMA survey showed 90 percent of physicians reported prior authorization has a negative impact on patient clinical outcomes. Seventy-four percent said prior authorization can lead to treatment abandonment, and 24 percent said prior authorization led to a serious adverse event for a patient in their care.⁴⁵ The financial toll, emotional distress, and psychological effects on patients of treatment delays and confusing prior authorization procedures can be substantial.⁴⁶ These effects could also lead to patients avoiding treatment or seeking care in the future, ultimately undermining the patient-physician relationship and the physician’s ability to provide the best care for their patients. Reducing the prior authorization burden would return some of the physician’s autonomy and help ensure the patient receives the appropriate care, helping to strengthen the relationship between patient and physician.

Telehealth

Telehealth has been a tool for delivering remote patient care for many years but was not widely adopted. The onset of the COVID-19 pandemic in early 2020 drastically expanded the use of telemedicine services for patient care delivery.⁴⁷ Connectivity issues or general technological challenges may create barriers for effective telemedicine visits, and access to the technology may not be available for all patients, leading to the potential risk of jeopardizing the patient-physician relationship. Telehealth has proven its value to the practice of medicine, and there are many benefits to both the patient and physician,⁴⁸ yet some concerns about telehealth contributing to the erosion of the patient-physician relationship remain. Although AMA policy supports establishing patient-physician relationships via telehealth when clinically appropriate, it is still recommended that the establishment of a new patient-physician relationship take place during an in-person visit.⁴⁹ This in-person connection, a bond-forming element based on human awareness of personal space and the healing effects of human touch and face-to-face interactions, is integral to successful patient-physician relationships.⁵⁰

AMA advocacy, research, and resources

Our AMA has historically advocated on physicians' behalf for changes in policy and practice that would improve and enhance the patient-physician relationship. AMA's ongoing advocacy aims to reduce documentation burden, reform prior authorization requirements, increase transparency, and improve EHR technology so physicians can spend more time with their patients.

In addition to its tireless advocacy efforts, our AMA has worked on many levels to develop resources and education for physicians to help enhance their communication and relationship with their patients. In addition, the AMA has dedicated significant resources to researching the factors that detract from physicians' ability to provide high-quality patient care, including but not limited to the studies previously referenced in this report. AMA supports and carries out research efforts aimed at understanding and identifying solutions to the issues that create barriers between physicians and their patients. The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physician's work day.¹⁶ The AMA published a report on bullying in the practice of medicine and the effects it can have on physician well-being and their ability to provide high-quality patient care.⁵¹ The AMA has also published research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development.^{33, 52} The AMA's research includes a time-motion study to determine how much and in what ways physicians spend time completing tasks in their EHRs. The AMA has also published eight EHR usability priorities, which outline and support the need for better usability, interoperability, and access to data for both physicians and patients.⁵³ If followed, these priorities will enable the development of higher-functioning, more efficient EHRs, contributing to a reduction in the burden that EHR use places on patient care.

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

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

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

The AMA and CMS in 2019 worked together to achieve the first overhaul of E/M office visit documentation and coding in more than 25 years. Specifically, Medicare began to allow physicians to document review and verification of history entered into the medical record in lieu of re-entering the same information. For established patients, history and examination already contained in the medical record no longer needs to be re-entered and physicians can document only what has changed and relevant items that have not changed since the patient's last visit. The changes implemented are a significant step in reducing administrative burdens that get in the way of patient care and will allow physicians to spend more time with their patients, one of the key elements to a meaningful patient-physician relationship.

Considering the variation in patients, case complexity, and specialty-specific needs, the AMA is not in favor of imposing a universal minimum time for patient visits and supports these changes that enable physicians more flexibility determining the appropriate amount of time to dedicate to their patients. The AMA is collaborating with the University of California San Francisco to investigate changes in documentation and coding time, perceived burden and physician burnout throughout the phases of the E/M coding changes. The outcomes of this research will help institutional leaders and physicians identify additional opportunities to reduce physician administrative burden and increase time spent with patients. This research will also prioritize and inform advocacy efforts with federal (e.g., CMS) and state regulators, commercial plans and EHR vendors to further address issues such as coding, documentation, and burden reduction on behalf of physicians, their practices and patients.

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

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

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

CONCLUSION

Many factors contribute to the dynamics of a relationship between a patient and physician, including shared decision-making, online health and medical information, health literacy, trust, implicit bias, physical settings, communication, and external influences. These factors have been studied and written about at length. The evidence shows that patients and physicians both have better experiences when they feel they have adequate time for talking and making decisions about treatment together. Physicians have better experiences when they have assistance with documentation so they can spend more of their visit face-to-face with their patients rather than looking at the computer. Physicians are more satisfied with their patient relationships when patients trust them. Patients are more satisfied with their clinic visits and their physicians when they feel they have been listened to and allowed to talk about their concerns. Improving communication and preventing implicit biases from influencing care decisions are ways both physicians and patients can ensure their relationships with one another are healthy, trusting, and productive.

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

RECOMMENDATION

The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be filed.

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10. PROTESTER PROTECTIONS (RESOLUTION 409-NOV-20)

Reference committee hearing: see report of Reference Committee D.

**HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 409-NOV-20
REMAINDER OF REPORT FILED
See Policy H-145.969**

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

- (1) advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States; and

- (2) encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm.

BACKGROUND

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

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

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

DEFINITIONS

Definitions are critically important to this issue. For the purposes of this report, key terms are defined as follows:

Crowd control is defined as techniques used to address civil disturbances (breach of the peace or an assembly where there is a threat of violence, destruction of property, or other unlawful acts), to include a show of force, crowd containment, dispersal equipment and tactics, and preparations for multiple arrests.⁵

Crowd management is defined as techniques used to manage lawful assemblies (demonstrations, marches, or protests) before, during, and after the event for the purpose of maintaining lawful status through event planning, pre-event contact with event organizers, issuance of permits when applicable, information gathering, personnel training, and other means.⁵

Demonstrations are defined as the lawful assembly of persons organized primarily to engage in free speech activity. These may be scheduled events that allow for law enforcement planning. However, lawful demonstrations can devolve into civil disturbances that necessitate enforcement actions.⁵

Kinetic impact projectiles (KIPs), commonly called rubber or plastic bullets, are defined as projectiles designed and intended to deliver non-penetrating impact energy. KIPs are designed to incapacitate individuals by inflicting pain or sublethal injury.³ Some KIPs target an individual with a single projectile, while others target a group by scattering multiple projectiles. There are numerous types of KIPs available, including "rubber bullets," which are spherical or cylindrical projectiles and can be made of hard rubber, plastic, or polyvinylchloride. The term "rubber bullets" is also often used to describe KIPs made of a composite of plastic and metal fragments as well as metal bullets surrounded by a coating of plastic or rubber.

Chemical irritants, also referred to as riot control agents, are chemical compounds that temporarily make people unable to function by causing irritation to the eyes, mouth, throat, lungs, and skin.⁶ Several different chemical compounds are used as chemical irritants, including oleoresin capsicum ("pepper spray"), hexachloroethane ("smoke grenade"), the "tear gases" chloroacetophenone, chlorobenzylidenemalononitrile (CS), chloropicrin, bromobenzylcyanide, dibenzoxazepine, as well as combinations of various agents. Chemical irritants come in many forms (liquids, solids, fine powders), thus many formulations and dispersion technologies are used. Most are released into the air as fine droplets or particles using propellants, solvents, or explosives.

EXISTING AMA POLICY

Existing AMA policy does not address the use of chemical irritants or kinetic impact projectiles for crowd control. Policy H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” encourages the study of the public health effects of physical or verbal violence between law enforcement officers and the public, particularly within ethnic and racial minority communities; encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement; supports requiring the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies; and encourages appropriate stakeholders, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

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

DISCUSSION

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

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

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

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

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

Several studies have examined ocular injuries caused by KIPs and have found that the use of KIPs increase the incidence of debilitating ocular trauma.¹² For example, a study investigating cases of ocular trauma from KIPs during

the civil unrest in Chile between October 18 and November 30, 2019 identified. KIPs as the suspected cause in 182 cases (70.5 percent).¹³ Thirty-three cases had total blindness and 90 cases (49.5 percent) had severe visual impairment or were blind at first examination. Around 20 percent of the cases caused by KIPs had open-globe trauma.¹³ Compared to other causes of ocular trauma, KIPs were related to a more severe loss of visual acuity and a higher frequency of open-globe injuries.¹³

Effects of Chemical Irritant Exposure

Chemical irritants such as tear gas and pepper spray are banned from use in warfare under the United Nations Chemical Weapons Convention (CWC). However, the CWC and local regulations stipulate that certain chemical agents may be used for riot control when officers give people adequate warning before releasing the agents and people have a reasonable route to escape any gas.¹⁴ Chemical irritants used in crowd control have historically been considered by law enforcement to be safe and to cause only transient pain and lacrimation. However, in a recent publication, the National Institute of Justice notes that the deployment of pepper spray should be constrained and discusses the negative effects of pepper spray use.¹⁵ Attempts have been made to catalogue the chemical irritants used by law enforcement but have been unsuccessful because of the number and variability of agencies and policies.¹⁶

Mixed reports exist regarding the effects of chemical irritants on people who are exposed. Some reports note that without medical attention, the effects of pepper spray and tear gas wane within several minutes; that significant adverse clinical effects, life-threatening conditions, and long-term effects are rare; and that death caused by chemical irritant exposure is unlikely.^{15,17,18} However, numerous newer reports indicate that the use of these chemicals may cause serious injuries, have a significant potential for misuse, and cause unnecessary morbidity and mortality.¹⁹⁻²¹ A systematic review found that among 9,261 injuries from chemical irritants, 8.7 percent were severe, two were lethal, and 58 caused permanent disabilities.²²⁻²⁴ Studies have identified chronic bronchitis, compromised lung function, and acute lung injury as consequences of chemical irritant exposure.²²⁻²⁴

The International Association of Chiefs of Police (IACP)

The IACP, the world's largest professional association for police leaders with more than 31,000 members in over 165 countries, has established guidelines for managing crowds, protecting individual rights, and preserving the peace during demonstrations and civil disturbances. It is the policy of the IACP to "protect individual rights related to assembly and free speech; effectively manage crowds to prevent loss of life, injury, or property damage; and minimize disruption to persons who are not involved."⁵

ICAP's guidance provides that impact projectiles shall not be fired indiscriminately into crowds.⁵ Non-direct (skip-fired) projectiles and munitions may be used in civil disturbances where life is in immediate jeopardy or the need to use the devices outweighs the potential risks involved.⁵ Direct-fired KIPs may be used during civil disturbances against individuals engaged in conduct that poses an immediate threat of death or serious injury.⁵ A verbal warning should be given prior to the use of KIPs when reasonably possible.

IACP provides that aerosol restraint spray, or oleoresin capsicum (OC), may be used against individuals engaged in unlawful conduct or actively resisting arrest, or as necessary in a defensive capacity when appropriate.⁵ OC spray shall not be used indiscriminately against groups of people where bystanders would be affected, or against passively resistant individuals.⁵ High-volume OC delivery systems may be used in civil disturbances against groups of people engaged in unlawful acts or endangering public safety and security when approved by the incident commander.⁵ Whenever reasonably possible, a verbal warning should be issued prior to the use of these systems.

CS (2-chlorobenzalmalononitrile) chemical agents are primarily offensive weapons to be used with the utmost caution. IACP 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. IACP 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 protestors participating in demonstrations, including current campaigns sparked by the death of George Floyd.”³² Citing significant short- and long-term respiratory health injury and likelihood 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 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.

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11. REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOD ACTION: FILED

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.

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) REPEAL

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

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the House of Delegates.

12. ADOPTING THE USE OF THE MOST RECENT AND UPDATED EDITION OF THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT (RESOLUTION 606-NOV-20)

Reference committee hearing: see report of Reference Committee F.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 606-NOV-20
REMAINDER OF REPORT FILED
See Policy H-365.976**

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.

**13. AMENDING THE AMA'S MEDICAL STAFF RIGHTS AND RESPONSIBILITIES
(RESOLUTION 710-NOV-20)**

Reference committee hearing: see report of Reference Committee G.

**HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy H-225.942

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

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

Preamble

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

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

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

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

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:

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.

14. PHARMACEUTICAL ADVERTISING IN ELECTRONIC HEALTH RECORD SYSTEMS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-478.961

INTRODUCTION

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

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

BACKGROUND

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

AMA POLICY

The AMA supports the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people (Policy H-100.995, “Support of American Drug Industry”). In addition, the AMA supports a ban on direct-to-consumer

advertising for prescription drugs and implantable medical devices (H-105.988, “Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices”).

AMA *Code of Medical Ethics* Opinion 9.6.7, “Direct-to-Consumer Advertisements of Prescription Drugs,” states physicians should remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products. The Opinion also states physicians should 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 (4) opposes the preferential placement of brand name medications in e-prescription search results or listings; and (5) will encourage e-prescribing and EHR companies to ensure that the generic medication name will appear first in e-prescription search results and listings.

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**15. REMOVING THE SEX DESIGNATION FROM THE PUBLIC PORTION
OF THE BIRTH CERTIFICATE
(RESOLUTION 5-I-19)**

Reference committee hearing: see report of Reference Committee D.

**HOD ACTION: RECOMMENDATIONS ADOPTED
 IN LIEU OF RESOLUTION 5-I-19
 REMAINDER OF REPORT FILED
 See Policy H-65.967**

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 individual's 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.

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16. FOLLOW-UP ON ABNORMAL MEDICAL TEST FINDINGS (RESOLUTION 309-I-19)

Reference committee hearing: see report of Reference Committee D.

**HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 309-I-19
REMAINDER OF REPORT FILED
See Policy D-160.914**

INTRODUCTION

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

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

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

CURRENT AMA POLICY

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

BACKGROUND

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

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

The Office of the National Coordinator for Health Information Technology (ONC) offers Safety Assurance Factors for EHR Resilience (SAFER) Self-Assessment Guides to address safety concerns faced by health care organizations.²⁹ The SAFER guide on Test Results Reporting and Follow-Up includes a checklist and recommended practice worksheets with rationale and examples for how to implement. The self-assessment facilitates engagement of clinician

leadership to reach consensus on priorities, resources and methods of ensuring that recommended practices for communication and management of diagnostic test result are in place.

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

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

Potential Impacts for Physicians and Patients

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

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

Online patient portals have the capacity to provide early access to test results in the absence of meaningful interpretation by a physician.³⁴ While patients should have timely access to their test results, providing such information without additional context or explanation at the appropriate health literacy level may increase anxiety for some patients.³⁵ Patients may also encounter challenges accessing the results or require additional support.³⁶

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

CONCLUSION

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

RECOMMENDATIONS

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

Our American Medical Association encourages relevant national medical specialty societies to develop and disseminate evidence-based guidelines for communication and follow-up of abnormal and critical test results to promote better patient outcomes.

Our AMA will work with appropriate state and medical specialty societies to highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings to promote better patient outcomes.

Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care while ensuring appropriate privacy safeguards.

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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.

17. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES: FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

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

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

The following organizations were reviewed for the 2021 Special Meeting:

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

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

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

RECOMMENDATIONS

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

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

APPENDIX***Exhibit A - Summary Membership Information***

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

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

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

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

G-600.022

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

1. The organization must not be in conflict with the Constitution and Bylaws of our AMA.
2. The organization must demonstrate that it represents and serves a professional interest of physicians that is relevant to our AMA's purpose and vision and that the organization has a multifaceted agenda (i.e., is not a single-issue association).
3. The organization must meet one of the following criteria: (i) the organization must demonstrate that it has 1,000 or more AMA members; or (ii) the organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA; or (iii) that the organization was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of our AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within the profession and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must meet the above guidelines.

Exhibit C

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

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

- 8.5.2** If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.
- 8.5.3** Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
- 8.5.3.1** If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.
- 8.5.3.2** If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:
- 8.5.3.2.1** The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.
- 8.5.3.2.2** The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

18. DIGITAL VACCINE CREDENTIAL SYSTEMS AND VACCINE MANDATES IN COVID-19

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 230
ADDITIONAL PROPOSED RECOMMENDATION REFERRED FOR DECISION
REMAINDER OF REPORT FILED
*See Policy H-440.808***

The COVID-19 pandemic has had devastating health consequences and caused widespread, serious disruption in the U.S. and worldwide. As of May 2021, there have been more than 32 million cases of COVID-19 in the U.S. and 576,238 COVID-19-related deaths. In 2020, the estimated age-adjusted death rate increased 15.9 percent compared with 2019 and COVID-19 was the underlying or a contributing cause of 377,883 deaths; COVID-19 death rates were highest among males, older adults, and American Indian/Alaska Native, Hispanic, and Black persons.¹ According to the National Center for Health Statistics, COVID-19 was the third leading underlying cause of death in 2020, replacing suicide as one of the leading causes of death.²

The use of vaccine credentialing and/or mandatory vaccination has been urged to speed the return to "normal." Although existing AMA policy provides guidance on routine vaccinations, COVID-19 and COVID-19 vaccines present unique and challenging circumstances for which additional policy is needed.

DIGITAL VACCINATION CREDENTIAL SERVICES (DVCS)

With more people getting vaccinated and a strong desire from the public to return to “normal” life, many companies are developing digital vaccine credential services (DVCS), often referred to by the misnomer “vaccine passports.”* The term DVCS collectively refers to a digital vaccine credential issuer, a digital vaccine credential app/platform, or a digital vaccine credential requestor. A vaccine credential issuer refers to those who administer vaccines to individuals (e.g., physician offices, hospitals). A digital vaccine credential app/platform is the technology an individual would use to obtain a digital credential stating they have been vaccinated (i.e., a digital form of paper vaccination record). A digital vaccine credential requestor is any entity that seeks to view and possibly utilize the digital credential for some purpose (e.g., a sports venue that will only admit individuals who possess digital vaccine credentials).

Requiring proof of vaccination is not a novel concept in this country; for example, most jurisdictions require students to provide proof of vaccination prior to attending not only elementary and secondary schools, but also higher education and childcare facilities. Additionally, international travel often requires proof of vaccination against certain communicable diseases. Clearly these are specific use cases that do not apply to the country’s entire population. DVCS, however, may be utilized by hundreds of millions of people across society depending on the scope of digital vaccine credential requestors planning to require digital vaccine credentials for entry into or participation in certain events, facilities, and venues, helping to reduce transmission and at the same time allowing participants to signal that they mutually share the protection of each having been vaccinated. Some envision DVCS potentially serving as a “critical driver for restoring baseline population health and promoting safe return to social, commercial, and leisure activities.”³ There are already nearly 20 DVCS in development, and multiple states and other jurisdictions have developed their own DVCS.⁴

DVCS may provide multiple benefits that paper records do not. For example, paper records can be lost. They may also require individuals to make additional trips to physician offices or pharmacies to pick up copies of their vaccination records, which can be burdensome to both the patient and practice. Nor is it clear how individuals who received vaccine at mass vaccination events can obtain records after the event. Moreover, patients receive vaccinations at different stages throughout their lives. Additionally, paper vaccination records can be stolen or fraudulently produced—something already happening with COVID-19 vaccination cards.⁵ Accordingly, DVCS potentially serve as a reliable, convenient, and accurate mechanism by which one can demonstrate and verify their vaccination status. The DVCS seek to authentic vaccination status by providing a direct, electronic way to trace back where the information came from (a concept in health information technology known as provenance).

The use of DVCS is not without potential pitfalls, however. Some challenges are practical, such as ensuring that DVCS can successfully access source data stored in different formats, whether hardcopy or electronic, among the many entities that are providing COVID-19 vaccination. Significant questions remain around the ethics of DVCS usage, support, and mandates.⁶ Some states have or are attempting to ban the use of DVCS outright, reinforcing political divisions over COVID-19 vaccination.⁷ Even though the Biden administration has stated that it will not develop a federal DVCS, the AMA believes there is still an important role for the federal government to play in establishing, publicizing, and enforcing guidelines to which all DVCS must adhere.⁸

First, the use of DVCS must not outpace vaccine availability. Although supplies are rapidly increasing, vaccines are not yet universally accessible, particularly to individuals in historically marginalized and minoritized communities. Until all Americans are easily able to access vaccines and trusted DVCS, we must guard against programs that appear to confer special social privilege based on one’s COVID-19 vaccination status. Additionally, the pandemic has demonstrated our country’s stark disparities in access to technology, inequitable technology innovation and design priorities, and digital literacy. A DVCS must ensure that individuals can access their credentials in hard copy. Relatedly, both access to DVCS and DVCS functionality, content, and user interface must be designed with and for historically minoritized and marginalized communities. DVCS must address issues of culture, language, digital

* AMA prefers the term “vaccine credential” to the frequently used “vaccine passport.” The latter is misleading and its purposes can be misunderstood. Passports are legal documents issued by nations to control entry and exit from a country and may also be used as legal identification. Vaccine credentials, in contrast, are medical documents that document an individual’s vaccination status. See Benjamin GC, *Vaccine Passports Are a Premature Solution to a Challenging Problem* (April 19, 2021) available at <https://leaps.org/vaccine-passports-are-a-premature-solution-to-a-challenging-problem/particle-1>.

literacy, and access to broadband services to ensure that the tools are usable by all individuals and do not de facto discriminate.

Second, most of the digital vaccine credential apps/platforms individuals may use to obtain their digital vaccine credentials will not be subject to any sort of federal privacy protections (including the health sector specific privacy law, the Health Insurance Portability and Accountability Act of 1996 [HIPAA]). The AMA has advocated very strongly in recent years that the use of apps outside of HIPAA—despite their potential to improve individual access to one’s own health information—pose a significant threat to the privacy of such information.⁹ Failure to address the lack of privacy requirements in apps can also stymie the uptake of innovative technologies that could potentially improve public health. Such failure, along with concern about surveillance, lack of coordination, and distrust of technology companies contributed to sluggish adoption of digital contact-tracing apps early in the pandemic.

Vaccine credentialing apps are likely to face similar concerns regarding privacy, surveillance, and apprehension. Specifically, individuals subject to disproportionate rates of incarceration and heightened surveillance based on immigration status or race; those with stigmatized health conditions such as substance use disorder, HIV/AIDS, and other sexually transmitted infections; LGBTQ individuals; unhoused people; and individuals with disabilities may be wary of DVCS due to the possibility that third parties will share their data with employers, insurers, landlords, the police, or other government agencies. Accordingly, the AMA recommended that the federal government develop guidelines around data governance, including (but not limited to) utilization of classic data privacy principles such as data minimization (i.e., only collecting the minimum amount of information necessary to function as a credential), data sunset rules (i.e., discarding data once it is no longer needed), and data sharing defaults that require users to opt-in to broader, automatic data sharing (as opposed to forcing users to take additional steps to opt-out of such sharing).

Lastly, DVCS policy is likely to shift as vaccine availability increases and scientific evidence of effectiveness or limitations grows.¹⁰ DVCS will need updates to accommodate these changing requirements. No one organization, app marketplace, or industry will be able to track, monitor, and provide individuals meaningful information on credentialing services, including data use policies or app adherence to development principles. Individuals should have access to a single source of truth where they can clearly understand features, functions, and the policies by which apps abide. Accordingly, the AMA has recommended that DVCS register with the federal government after meeting the above-described federal guidelines and be included on a public-facing list of all registered DVCS along with clear and understandable information about each DVCS.

VACCINE MANDATES

As supplies of COVID-19 vaccines become available to meet demand vaccine hesitancy is high, leading to doubt that the U.S. will be able to achieve “herd immunity,”¹¹ there have been calls for mandating vaccination, especially for frontline health care workers, first responders, or others considered essential workers, and students.¹² Mandates are legal and enforceable for interventions that have been licensed by the U.S. Food and Drug Administration (FDA), but there are questions about whether that is also the case for interventions released under an Emergency Use Authorization (EUA), as COVID vaccines were initially.^{13,14} However, Pfizer/BioNTech recently submitted a Biologics License Application (BLA) for their COVID-19 vaccine, asking for expedited review and it is expected that FDA will soon grant a BLA.¹⁵

Vaccine mandates serve a fundamentally different purpose from DVCS: where DVCS offer individuals opportunity to resume at least a semblance of “normal” activities in the absence of herd immunity,¹⁶ mandates are promoted precisely as a means to achieve that immunity. The primary intent of a mandate is to protect the health of the community, with benefit to the individual secondary. Like DVCS, vaccine mandates raise concerns about equity, but given the different goal to which they are directed, they do so in a somewhat different way. DVCS ease restrictions on individuals but may unfairly exclude those who would choose to be vaccinated but cannot access vaccine. Mandates intentionally impose restrictions by obviating personal choice and requiring everyone to be vaccinated, with only limited exceptions, when voluntary uptake does not reach levels that will achieve the public health goal of herd immunity. Importantly, privacy is less a concern with respect to vaccine mandates than are issues of autonomy.

Historically, public health restrictions have been imposed on individual autonomy in the interest of protecting the health of the community, and the legality of state-imposed vaccine mandates is well-established. Since the landmark case *Jacobson v. Massachusetts* in 1905, the law has generally favored states’ ability to exercise the police power to compel vaccination “as the safety of the general public may demand” even at the expense of individual liberty.¹⁷

All states currently employ vaccine mandates in some form, most in alignment with the recommendations of the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP). As noted previously, all states require students to provide proof of vaccination for specified vaccines before they are permitted to attend school. Many require staff of health care institutions, public and private, to be vaccinated for a range of infectious diseases, including seasonal influenza, to protect patients, staff, and the broader community. All states permit medical exemptions for individuals who have contraindications for vaccinations. Some allow parents or guardians to opt out of vaccination requirements if they object on the basis of religious beliefs (44 states), or personal, moral, or other beliefs (15).

Mandates that allow non-medical exemptions are problematic. AMA policy supports eliminating such exemptions, and further recommends that states have processes in place to determine which vaccines will be mandatory for admission to school and other identified public venues and that such mandates be based on ACIP recommendations.¹⁸ Policy also recognizes that health care workers have strong obligations to accept vaccination voluntarily, particularly for vaccine preventable diseases that are or may become epidemic or pandemic that pose significant medical risk or threaten the availability of the health care workforce.¹⁹ AMA policy further encourages use of mechanisms to encourage vaccine uptake, such as providing vaccination at no cost for employees, up to and including making vaccination a condition of employment.²⁰

Research has demonstrated that vaccine mandates, and the elimination of non-medical exemptions to those mandates, are effective at increasing immunization rates. COVID-19 vaccination is a critical prevention measure to help end the COVID-19 pandemic. The three COVID-19 vaccines currently authorized by the FDA for emergency use and recommended for use in the U.S. population by the CDC as recommended by the ACIP have been shown to be effective against SARS-CoV-2 infections, including the prevention of severe disease and death. According to the CDC, as of May 7, 2021 about 45 percent of the total U.S. population have received one dose of vaccine and about 33 percent have been fully vaccinated.²¹ However, the number of administered vaccine doses is decreasing. There are currently five SARS-CoV-2 variants of concern circulating for which there is evidence of an increase in transmissibility, more severe disease, significant reduction in neutralization by antibodies generated during previous infection or vaccination, reduced effectiveness of treatments or vaccines, or diagnostic detection failures.²²

Whether it is ethically acceptable for public or private entities to mandate vaccination as a condition of access to employment; education; or other activities, goods, or services requires thoughtful balancing of multiple considerations, including how readily the disease in question is transmitted; what medical risk the disease represents for individuals and the community at large; how risks of exposure are distributed across the population; the safety and efficacy of available vaccine(s); the effectiveness and appropriateness of vaccination relative to other strategies for preventing disease transmission; the medical value or possible contraindication of vaccination for the individual; and the prevalence of the disease. The more readily transmissible a disease and the greater the risk to those with whom an infected individual comes in contact relative to risks of vaccination, the stronger the argument for mandatory vaccination. Given the high rate of asymptomatic transmission in COVID-19, vaccinating the greatest number of individuals possible is critical. Yet despite their effectiveness as public health tools, vaccine mandates are a blunt instrument and may carry the risk of further eroding trust and ultimately undermining public health goals.

Mandates are inherently coercive and have the potential to impose burdens unequally across communities. For example, employer mandates that put livelihoods at risk may be especially onerous in communities where opportunities for employment are limited. The COVID-19 pandemic has already had devastating effect among marginalized and minoritized communities for individuals who have had no choice but to accept the risk of disease to preserve their livelihoods. Moreover, mandating vaccination may further alienate individuals who are mistrustful of authority, of vaccines generally, or of COVID-19 vaccines specifically even while it serves important public health goals. They should therefore be implemented with these considerations in mind and efforts made to minimize the potential to exacerbate existing inequities and adversely affect marginalized and minoritized communities to the extent feasible.

If successful in increasing vaccine uptake, efforts to promote voluntary vaccination would better respect recipients' autonomy and minimize the potential to impose disproportionate burdens on marginalized and minoritized communities. For example, Maryland is now offering \$100 to state employees who are fully vaccinated for COVID-19, while West Virginia is offering \$100 savings bonds to young residents to get vaccinated and Connecticut is partnering with a restaurant trade group to offer free drinks at certain restaurants for residents who have been vaccinated.²³ However, data are not yet available to indicate whether such efforts might be effective in persuading

enough individuals to seek vaccination voluntarily that the U.S. could avoid the need to mandate vaccination to control the spread of COVID-19.

With respect to health care professionals, guidance in the AMA Code of Medical Ethics provides that physicians have a professional ethical responsibility to be vaccinated, absent medical contraindications, and enjoins physicians who are not vaccinated for whatever reason to voluntarily take steps to protect patients, fellow staff, and the public, including refraining from direct patient contact.²⁴ Guidance further delineates the responsibilities of health care institutions to protect patients and staff from epidemic or pandemic disease, such as providing and requiring use of appropriate protective equipment and making vaccination readily available. Guidance recognizes that this responsibility may extend to requiring staff to be vaccinated (absent medical contraindication) when a safe, effective vaccine is available.

RECOMMENDATION

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

COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our AMA:

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials
 - a. vaccine is widely accessible;
 - b. equity-centered privacy protections are in place to safeguard data collected from individuals;
 - c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and
 - d. credentials address the situation of individuals for whom vaccine is medically contraindicated.
2. Recommends that decisions to mandate COVID-19 vaccination be made only:
 - a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
 - b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
 - c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
 - d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations.
3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust.
4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection.

Editor's note. The following amendment to add a fifth recommendation was referred for decision:

Recommends that vaccine credentials are not used to prevent immigration, that vaccines be offered upon arrival that vaccination is required to be accepted prior to entry in the US, and that vaccine mandates are uniformly applied regardless of citizenship.

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REPORTS OF THE SPEAKERS

The following reports were presented by Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker:

1. RECOMMENDATIONS FOR POLICY RECONCILIATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

RECOMMENDED RECONCILIATIONS ACCOMPLISHED

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.

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

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

- D-230.984, "Hospital Closures and Physician Credentialing"
1. Our AMA will develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact

location of those files. 2. Our AMA will: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations, including tracking hospital closures, as well as how and where these closed hospitals are storing physician credentialing information; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information, and report back to the House of Delegates at the 2019 Interim Meeting.

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

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

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

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

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

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

The Board of Trustees presented report 11-I-19 in fulfillment of this request. The policy will be rescinded.

Policies to be rescinded in part

- H-85.952, "Advance Directives During Pregnancy"
1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.
3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
~~4. The Council on Ethical and Judicial Affairs will consider examining the issue of advance directives in pregnancy through an informational report.~~

The Council on Ethical and Judicial Affairs reviewed ethics policy on advance care planning (Opinion 5.1), surrogate decision making (Opinion 2.1.2), and treatment at the end of life (Opinions 5.2, 5.3, 5.4, 5.5, and 5.6) and concluded that existing guidance is clear with respect to strong ethics practice regarding advance care planning and treatment decisions at the end of life. For this reason, Paragraph 4 of the policy will be rescinded.

- H-285.902, "Ban on Medicare Advantage "No Cause" Network Terminations"
1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network; b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies; c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder; d. Indicating to plans that failure to maintain complete and accurate directories, as well

as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: (i) civil monetary penalties; (ii) enrollment sanctions; or (iii) incorporating the accuracy score into the Stars rating for each plan; e. ~~Offering plans the option of using AMA/Lexis Nexis VerifyHCP system to update provider directory information;~~ f. Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.

2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year; b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy; c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; d. Evaluating alternative/additional measures of adequacy.

3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form; b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: (i) the number of contracted physicians in each specialty and county; (ii) the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.

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

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

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

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

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

- D-383.978, "Restrictive Covenants of Large Health Care Systems"
 - ~~1.—Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.~~
 - ~~2. Our AMA will study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.~~

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

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

2. REPORT OF THE ELECTION TASK FORCE

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

**HOUSE ACTION: RECOMMENDATIONS 1 TO 15, 17 TO 31, 33, 34, AND 36 TO 41 ADOPTED
RECOMMENDATION 35 ADOPTED AS FOLLOWS
RECOMMENDATION 16 REFERRED
RECOMMENDATION 32 NOT ADOPTED
REMAINDER OF REPORT FILED**

See Policies G-610.010, G-610.020, G-610.021, G-610.030 and D-610.998

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

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

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

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

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

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

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

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

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

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

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

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

Campaign Expense

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

CAMPAIGN MEMORABILIA

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

Some concern was expressed about doing away with the giveaways, because some candidates make a contribution to the AMA Foundation in lieu of a giveaway. Doing away with giveaways does not, however, preclude contributions to the Foundation. Anyone and everyone is not only invited but encouraged to donate to the Foundation. Moreover, over the last several years, few candidates have donated to the Foundation in lieu of providing a gift in the NFOB bag. Maintaining giveaways to facilitate relatively rare "in-lieu-of" donations to the Foundation seems a bit disingenuous, particularly as donors can just as easily proclaim their support of the Foundation in more efficient ways.

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

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

STICKERS, BUTTONS, and PINS

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

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

CAMPAIGN RECEPTIONS

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

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

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

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

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

In lieu of the multiple, competing receptions sponsored by individual campaigns, we are recommending that our AMA investigate the feasibility of sponsoring a welcome reception open to all candidates and all meeting attendees. Such a reception could allow any candidate the opportunity to be "featured" at the AMA reception. Featured candidates could

be allowed to set up in a space within the reception to visit with anyone who chooses to stop by or could choose to circulate among guests. Such an arrangement would do away with the receiving lines, about which the task force heard negative commentary, and the “forced stickering” that seems to occur whenever one enters the current receptions (see above for further discussion of campaign stickers). It would facilitate informal interaction between candidates and members of the House. Two-thirds of those responding to the survey of the House (Appendix D) indicated that they probably or almost certainly would attend such an event. Nothing in this recommendation would prevent other candidates who elect not to use this reception as their single allowed reception from attending. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain.

DINNERS, SUITES AND SUCH

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

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

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

CAMPAIGN LITERATURE

Brochures, letters, flyers and other campaign literature are often mailed to delegates before the Annual Meeting and distributed in the not for official business (NFOB) bag at the opening session. According to the survey of the House (Appendix D), these materials carry little impact on the delegate’s vote, regardless of how delivered, yet require significant expenditure to develop, print and distribute. Just six percent of respondents in the House find mailed literature important or very important. Slightly more than half declared that campaign literature was 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 to have available information about candidates’ background, experience and qualifications for the position they seek. We encourage elimination of all printed campaign materials while recommending an alternate electronic means of providing this information on a more equal platform. It seems few if any candidates “want” to send these materials, but most feel “required” to send because other candidates do. Because mailed materials carry the greatest expense we propose prohibiting these and would end the current process of the HOD office supplying a list of postal addresses to candidates. The election manual has not been printed since 2015

with no apparent negative effects, and in fact, when the House adopted the policy to move to an exclusively online manual, not a single concern was raised, nor have concerns been raised since.

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

ELECTRONIC COMMUNICATION

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

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

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

WEBSITES AND SOCIAL MEDIA

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

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

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

Fairness

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

INTERVIEWS

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

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

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

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

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

Of necessity for the June 2020 Special Meeting and now again for J-21, virtual interviews have been conducted by both the Speakers and individual caucuses and delegations. Given the overall positive feedback received, the task force recommends continuing the option for virtual interviews, including recorded interviews by the Speakers, in

advance of the meeting even after we return to in-person meetings. In addition, the Speakers would continue to conduct interviews with all candidates to be posted on the AMA website.

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

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

Distractions and Technology

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

VOTING PROCESS AND ELECTIONS SESSION

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

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

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

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

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

ANNOUNCEMENTS AND NOMINATIONS

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

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

The ETF believes that this loophole should be closed and that such announcements, just like any other campaign communication, sent to delegates before active campaigning is allowed would be a violation of campaign rules. In addition, we propose additional “official” announcement dates be established at which time additional announcement cards would be added to the AMA website and communication would be sent to the HOD. Under our proposal any candidate could still independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

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

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

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

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

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

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

Policy G-610.010, Nominations

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

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

(3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or

a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;

It is our understanding that Policy G-610.020 (3) was written more to define the start of active campaigning rather than to specify the timing of the nomination process. Note that this only specifies the Board "announcing the nominees" for council candidates; they are actually nominated by the Board at the Opening of the House. However, council candidates under our current rules may "announce" their candidacy at any point, even after the March deadline, and then be nominated "from the floor" by a delegate without completing an application or being considered by the Board. Review of available history did not identify a single instance when the Board did not "nominate" a council candidate who submitted an application. In reality the Board review of these candidates, who must be AMA members, is largely perfunctory. Procedurally nominations are declared open by the presiding officer, nominations are announced by the presiding officer or Board chair or made from the floor by a delegate. Then a motion is accepted to close nominations (typically the presiding officer will accept nominations be closed "without objection" once no further nominations appear to be pending even without a formal motion and second). To eliminate the confusion between nomination and submitting applications for review by the Board at their April meeting while maintaining the uniform March 15 deadline, the ETF recommends Policy G-610.010, "Nominations," paragraph 3 be amended.

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

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

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

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

NEWLY OPENED POSITIONS

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

Three general concerns have been expressed regarding "pop-up:" first, these individuals are being elected without the usual vetting; second, the process of new nominations and speeches before the HOD delays and distracts from policy

discussion; and third, the possibility of opening a seat has become a campaign strategy. In addition, our rules require a conflict of interest disclosure to be submitted before the election and presumably there should be ample opportunity for delegates to review the COI before voting. The ETF considered a number of potential solutions, including requiring candidates seeking another office to resign their current position, leaving the seat of a successful candidate vacant until the next meeting, delaying voting on these positions until the next day, or forcing potential candidates to declare in advance (an analysis of each of these options is included in Appendix E).

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

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

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

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

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

unnecessary burden on the candidates, but thought that this campaign experience and the resulting exposure of the candidate to the House would actually be beneficial to the candidate.

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

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

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

APPOINTING SELECT COUNCILS

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

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

In addition, these various methods all enjoy a plethora of candidates for each position which is in contrast to the few candidates, often unopposed, that run for councils. This may reflect a desire by some to avoid the election process which has been called into question by the resolutions that called for this report. It can be argued that more candidates would come forward if councils were appointed. Appointing one or more councils would lessen the number of interviews and remove most if not all associated campaign expenses.

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

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

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

THE ROLE AND INFLUENCE OF CAUCUSES

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

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

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

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

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

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

In addition, we recommend Principle 2 should be strengthened by adding the following: “This policy applies between as well as within caucuses and delegations.”

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

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

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

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

During the task force discussions, the question was raised about the size of caucuses. That is, should the size of a caucus be capped such that its influence—whether real or perceived—does not become outsized? The task force is

not making a recommendation on this matter at this time. It remains a question whether limitations on caucuses are within the House's authority at all. The ETF recommends continued monitoring of the effects of the adopted recommendations and consideration of future changes should they be deemed necessary.

THE DAY OF THE ELECTIONS

The task force heard suggestions for moving the day of the elections to earlier in the Annual Meeting, but does not favor such a change. First, determining who are the best candidates takes time, and the time devoted to interviews is valued by both candidates and the electorate. An earlier date would increase reliance on speeches and written materials rather than "getting to know" the candidates. Truncating the vetting process would be most harmful to lesser known candidates and those from smaller delegations. After examining the other days of the Annual Meeting, the ETF concluded that moving the elections would cause greater disruption to the already full agenda for each of the other days. The potential to adversely affect the elections by moving them forward seems too great to alter the day of the elections. Therefore, the task force favors implementation of the reforms proposed herein, which we believe will address the concerns underlying proposals to move the day of elections. (See Appendix F for detailed discussion of the ETF consideration of alternative days of election.)

ELECTION COMMITTEE

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

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

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

REVIEW OF IMPLEMENTATION

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

CONCLUSION AND RECOMMENDATIONS

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

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

Campaign Memorabilia

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

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

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

Stickers, Buttons, and Pins

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

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

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

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.

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;

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.

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;

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.

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;

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.

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;

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.

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;

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

[Editor's note: Recommendation 16 referred] **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.

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

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.

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.

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.

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;

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.

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.

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.

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;

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;

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.

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.

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.

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.

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.

Appointing Select Councils

[Editor's note: Recommendation 32 not adopted] 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.

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.

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.

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.

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.

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; ...

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.

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.

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

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

Review of Implementation

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

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

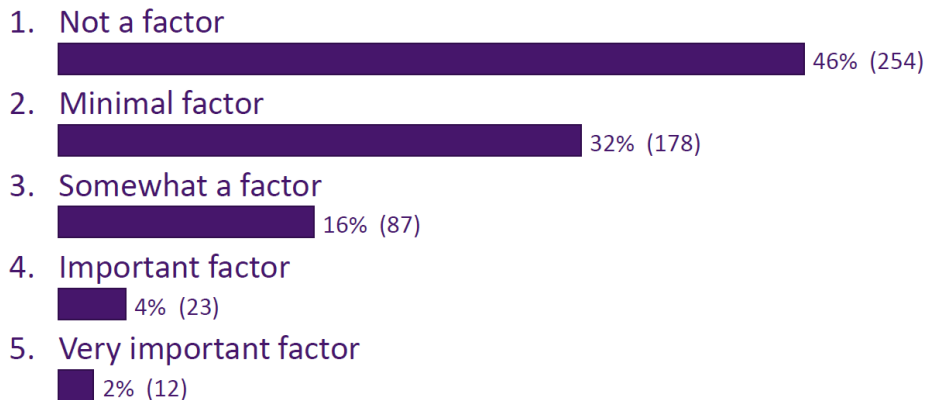
RESOLVED, That our AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:

- 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

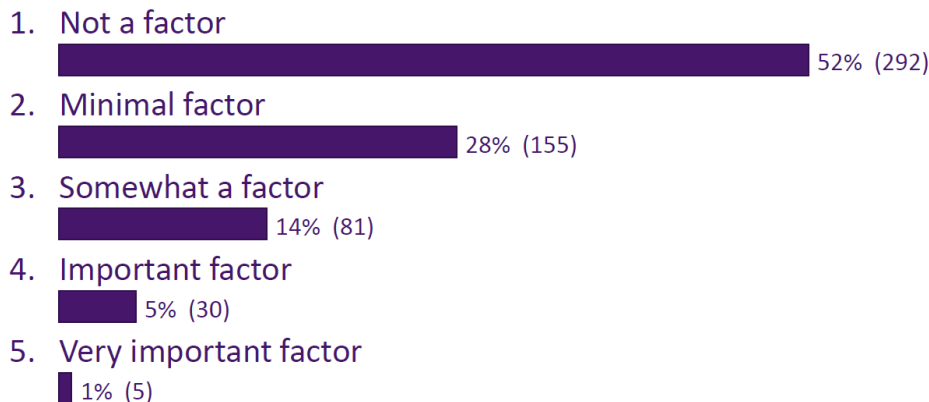
RESOLVED, That the task force report back to the HOD at the 2019 Interim Meeting.

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

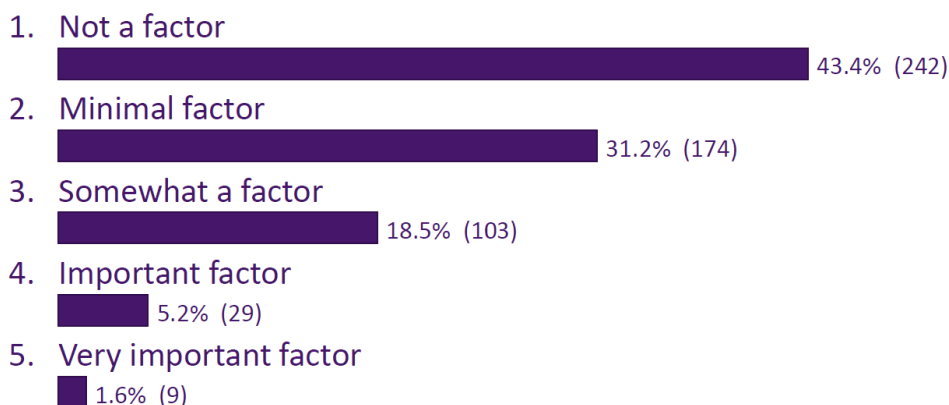
In determining your vote, how much of a factor are campaign brochures in the “Not For Official Business” bag?



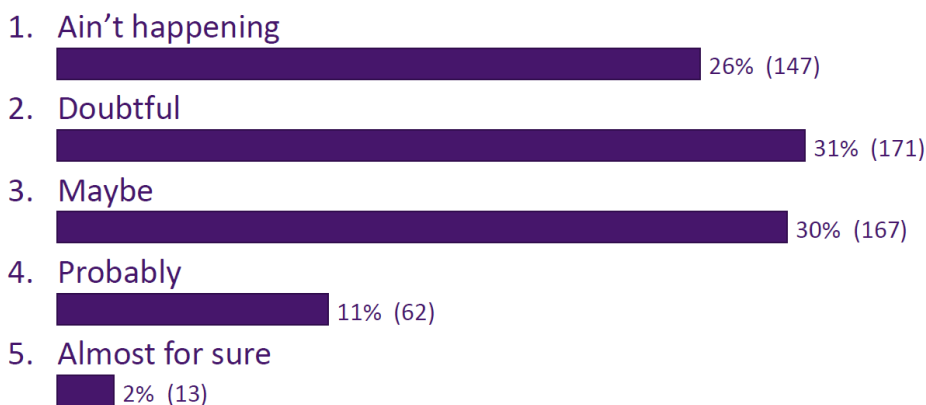
In determining your vote, how much of a factor are campaign brochures mailed to you before the meeting?



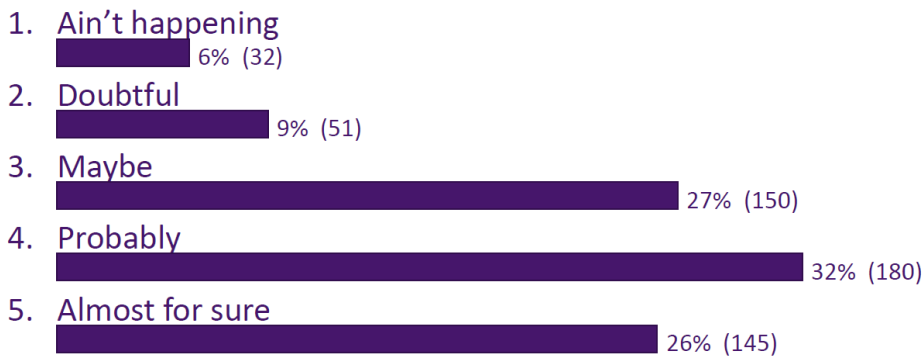
In determining your vote, how much of a factor are campaign materials emailed to you before the meeting?



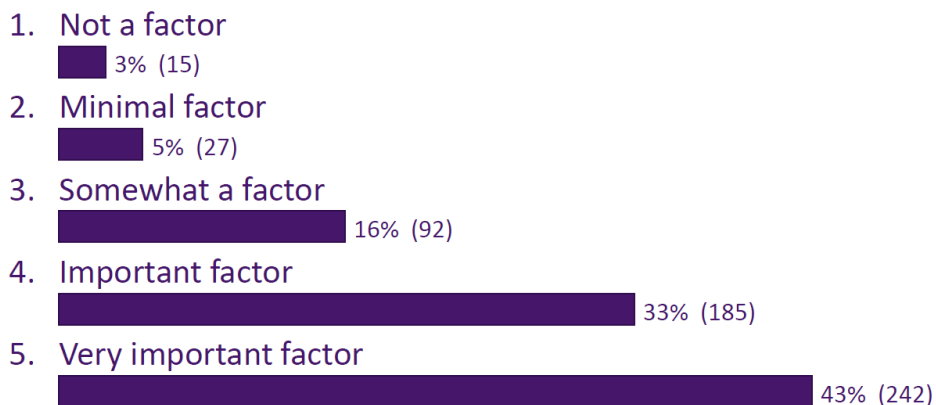
How likely are you to look at candidates' websites?



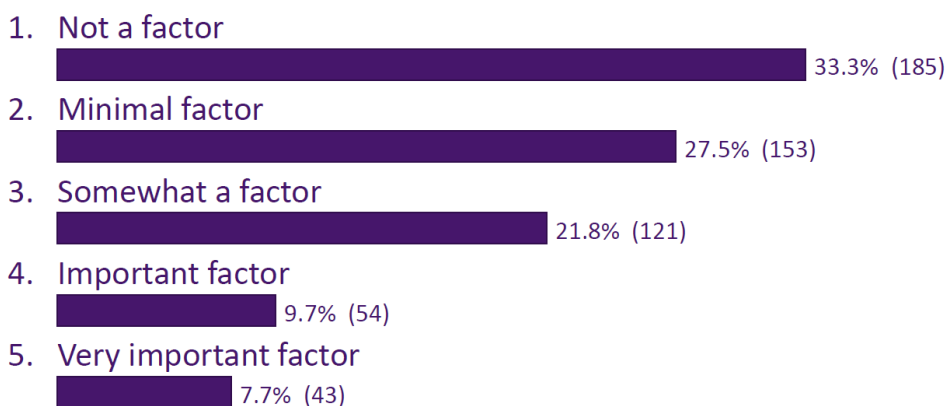
How likely are you to look at an enhanced AMA Elections website that would include links to the candidates' website and answers to specific questions given to candidates in advance?



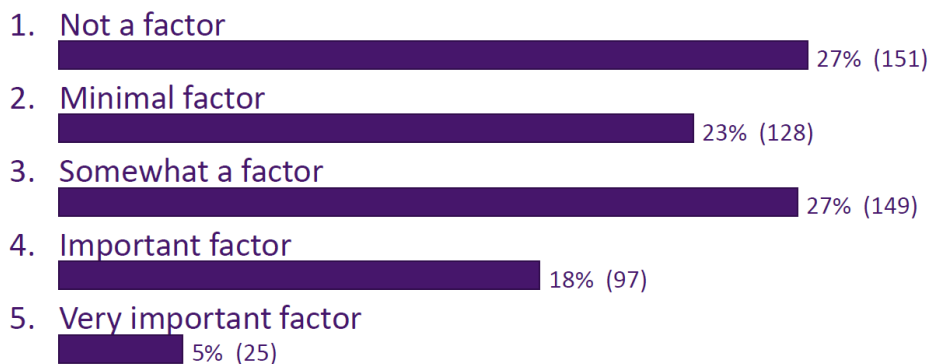
In determining your vote, how much of a factor is the interview process?



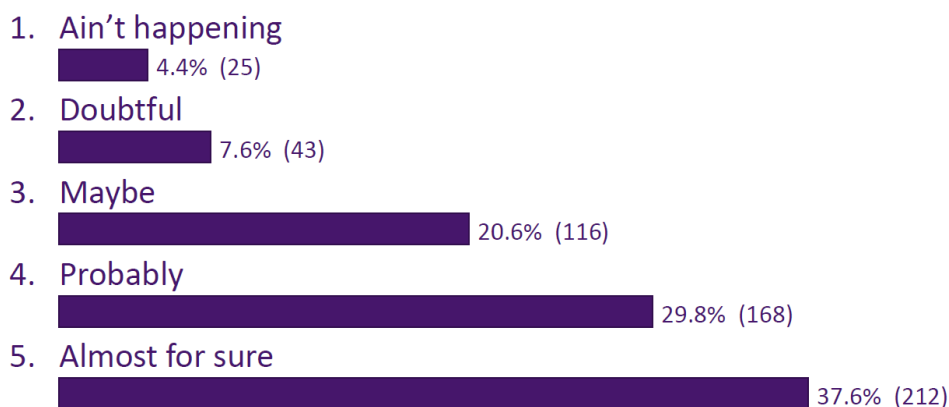
In determining your vote, how much of a factor are campaign receptions?



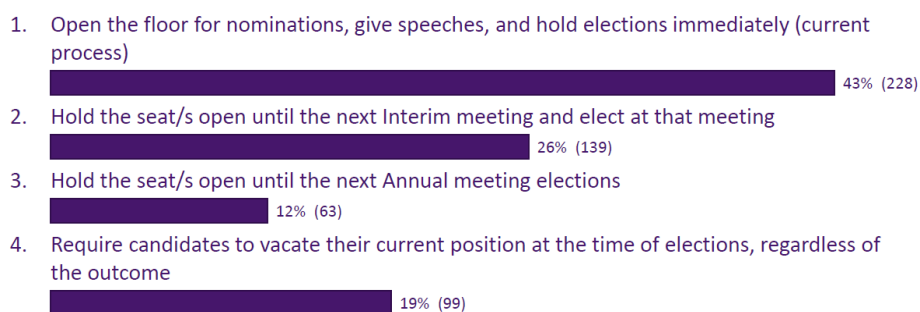
In determining your vote, how much of a factor are small group dinners and/or gatherings in suites at Interim, State Advocacy and NAC?



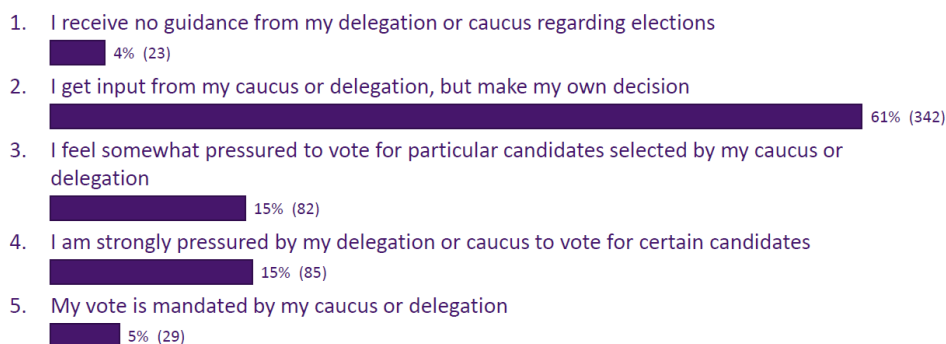
Would you attend a combined candidates party?



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



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



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 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.